S7695-2-F

LIVING IN THE GRAY ZONE:

HEALTH CARE NEEDS OF HOMELESS PERSONS

A Social Policy Needs Assessment Project

Initiated by the

Texas Department of Human Services

and funded jointly by the

Texas Department of Human Services

and the

Texas Commission on Alcohol and Drug Abuse

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August 1, 1988

DEDICATED TO HELEN J. FARABEE

ADVOCATE FOR TEXANS WHO ARE POOR, NEEDY AND ILL

ROLE MODEL FOR US ALL

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One day, as she stood talking with some visitors in the parking lot, the director of the local Food Bank in a Texas city noticed that the agency's flag looked grimy and tattered. When they left, she asked the receptionist to put the banner aside so that she could take it home to wash and mend. But the director forgot about her chore until the following morning, and she reminded the staff member once again.

In the evening, as the administrator prepared to leave, the flag pole was bare. The receptionist explained that she couldn't find out who had been raising and lowering the flag, and none of the staff or volunteers knew where it was kept. Routine pressures took over the director's time, and she went about her duties. The mystery of the flag occasionally pulled at her attention, but, after several days, she finally brought a new one and asked the driver to take care of it.

A week or so later, she learned the truth. Tom, a Vietnam veteran, had worked everyday as a volunteer at the Food Bank for the last six or seven months, unloading some of the heavier boxes and assisting with sorting in the warehouse. Joe, a buddy of his who helped occasionally, explained that Tom arrived early each morning to raise the flag and was usually the last to leave, after lowering it. During most of the spring and summer, he and Tom slept in a nearby park or in an alley behind the Food Bank. As it began to grow colder, Joe started drifting from one shelter to another to pass the nights, but Tom refused to accompany him, preferring to sleep out and to remain close to the Food Bank where he worked.

When questions started circulating round about the flag's ragged condition and who was responsible for it, Tom didn't feel disposed to give any answers. So early the next morning, he folded the banner one last time and walked off in the cold toward the highway, with his only possession, a star-spangled blanket, under his arm.

LIVING IN THE GRAY ZONE

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EXECUTIVE SUMMARY

The Texas Department of Human Services (TDHS) and the Texas Commission on Alcohol and Drug Abuse (TCADA) co-sponsored a statewide needs assessment study of homeless health care issues to obtain basic planning information which would allow them to determine if they should develop new initiatives to serve homeless people in Texas more effectively. Benedictine Health Resource Center coordinated a review of the literature and field research components with interviews of homeless people, direct service providers, homeless advocates and key decision-makers throughout the state. The process identified the following major issues.

(1) WHAT IS A HOMELESS PERSON?

- Homeless people have existed in the United States since its founding as a nation, but unusual events in the 1980s generated a larger number and a wider diversity of groups which captured the attention of community residents, as well as local, state, and federal policy makers.
- This stimulated a national debate about the causes and definition of homelessness, the difficulty of counting a reclusive population, and the challenges of providing appropriate services.
- Congress developed a federal definition of a homeless person, which includes those who lack a fixed, regular and adequate nighttime

residence, as well as those who are marginally housed, who sleep in temporary residences or who regularly sleep in unfit places.

* The best available estimates of the number of homeless people in the United States do not address the marginally housed, who can quickly become temporarily of permanently homeless:

-- If major shifts in employment or the availability of low-income housing occur in their communities; or

-- If socio-economic and personal factors generate family break-ups.

(2) WHO ARE THE HOMELESS?

* National research documents a major demographic change in the homeless population of the United States:

-- As many as one third of emergency shelter residents may be new to homelessness;

-- The majority are natives or long-term residents of their communities;

-- They are younger and include a growing percentage of women;

-- Many more racially\ethnically diverse groups are represented;

-- The number of families, both women with children and two-parent families, is increasing;

-- Many more adolescents have become "street people;" and

-- Preliminary data suggest that families of young women with teenagers and children or young minority males may be the fastest growing groups among the homeless population.

* This research project took a census one evening in emergency shelters and family crisis shelters across the state and discovered that:

-- Race/Ethnicity: 50% of the Texas shelter residents were White/Anglo, 28% Black and 18% Hispanic.

-- Gender and Age: Men comprised the majority, but 21% were women, and 18% were children. Three out of every five young people were children younger than 6, while another 30% were elementary school-aged between 6 and 11.

-- Veterans: About one third of the residents were veterans, the great majority of them being men, including 52% of the White/Anglo men.

-- Education: More than 53% of the homeless shelter residents had completed high school, but important racial/ethnic and gender differences existed in their levels of education.

-- Time in Texas: More than 37% of the homeless shelter residents were Native Texans. Blacks and Hispanics tended to be Native Texans at a higher rate than Whites/Anglos, and women were more likely to be Native Texans than men.

* Of those persons who were not native to Texas, the average time they had resided in our state was 8.4 years, and less than one third of this subgroup could be labeled as "recent arrivals."

-- First Use of Shelters: The majority of these residents seem to be new shelter users -- 60% had first used a shelter within the last 12 months and 28% within the last 30 days.

-- Employment: Even though they had to spend the night in a shelter, one third of the residents had some type of employment.

-- Ability to Work: Nearly two thirds of the men and almost half of the women perceived themselves as being able to work.

-- Physical Health - The Major Barrier to Employment: Every racial/ ethnic and gender group identified physical health problems as a barrier to employment.

-- Other Barriers to Employment - Major Differences: There were important differences in other types of barriers to employment identified by men and women and by racial/ethnic groups.

* The survey of Texas decision-makers documented that some health and human service administrators and community leaders do not seem to be aware of the changing population characteristics among homeless people in Texas and the implications for adaptations of community service delivery systems.

* Findings from this Texas project, although preliminary, document the extensiveness and seriousness of homelessness in our state and the need for primary care, as well as substance abuse and mental health services.

(3) WHAT ARE THE MAJOR HEALTH CARE PROBLEMS OF HOMELESS PEOPLE?

* A national homeless health care research study identified the most urgent health care needs of homeless people and the necessity of modifying our health care delivery system to serve them:

-- Primary health disorders

Acute: upper respiratory infections; trauma; malnutrition

Chronic: hypertension, gastrointestinal problems, peripheral vascular disease, serious dental problems, neurological disorders

-- Mental illness and assorted mental disorders

-- Alcohol and substance abuse

-- Multiple health disorders

Mental illness and alcoholism and/or polydrug abuse

Physical disabilities and mental illness and/or substance abuse

-- Reproductive health problems: pregnancy, sexually transmitted diseases, need for contraceptive counseling and services

-- AIDS: as a result of intravenous drug use, as well as sexual behavior

-- Homeless children are particularly vulnerable and experience much higher rates of health problems than do children nationally.

* Homeless people in Texas appear to suffer from the same patterns of acute and chronic health problems identified in the national research literature:

-- Most of their discomfort, illnesses and diseases result from being homeless: the effects of severe weather, lack of access to common medicine cabinet remedies and primary care services, loneliness, despair, malnutrition, and assault.

-- Homelessness exacerbates routine illnesses and generates emergency health conditions that could be easily prevented.

* The different characteristics of homeless groups and regional factors in Texas make it important to analyze such variations in order to plan for services:

-- Alcohol and drug abuse and different forms of mental illness are the major chronic health problems of homeless people in Texas, but there are very few public services available to them at the community level.

-- Many homeless people suffer from multiple health disorders in addition to substance abuse or mental illness, and this makes it almost impossible for them to obtain shelter or treatment.

-- Alcohol abuse is a typical problem for homeless men, but alcoholic women may be more seriously affected.

-- Polydrug abuse appears to be increasing among young homeless men and is often accompanied by violent, self-destructive behavior.

-- Homeless women are reported to have higher rates of severe mental illness, but the incidence of "chronic young adults" appears to be growing for both sexes.

-- Homeless women, adolescents and children are described as having suffered from abusive family relationships: their growing numbers emphasize the importance of primary health care and other preventive services.

* Texas survey results document that there is consensus among state decision-makers about the major unmet needs and priorities of community health care services needed by homeless people in our state.

-- All groups rank affordable housing and employment as the most important unmet needs of homeless people in Texas.

-- They identified alcohol and drug abuse, dental problems and mental illness as the most serious homeless health care problems.

-- Outreach programs to encourage homeless individuals to use existing services, special mental health services, walk-in clinics in accessible sites, and special alcohol and drug abuse services were targeted as the most needed homeless health care programs.

(4) WHAT KINDS OF REGIONAL FACTORS MUST BE CONSIDERED IN TEXAS?

- Texas regions and communities vary considerably in their local resources and their ability to respond to the needs of homeless and other indigent people.
- Some regions have different patterns of homeless individuals, and local decision-makers emphasize different areas of service to address.
  - The shelter census findings suggest that South and West Texas tend to have more young homeless people than other regions, while Northeast and West Texas have the lowest rates of Native Texans.
  - Local decision-makers in all regions identified affordable housing as the most important unmet need of homeless people, except for South Texas which ranked employment first. West Texas ranked job training much higher than other regions, while East Texas ranked medical care lower but mental health care higher.
  - Decision-makers in Northeast, Central and South Texas ranked outreach programs as the most needed homeless health care service, but Northeastern respondents picked special mental health services, and West Texans emphasized the need for easily accessible walk-in clinics.

(5) HOW CAN WE REDUCE AND ELIMINATE BARRIERS TO HOMELESS HEALTH CARE SERVICES?

- Structural and service delivery system barriers make it difficult for homeless people to use existing services; the factors blocking access include:
  - Organizational philosophies and staff characteristics (emphasis on crisis intervention rather than rehabilitative or prevention services, lack of knowledge or acceptance of public health orientation);

  - -- Availability of services (site, hours, cost, location of follow-up medication or treatment);
  - -- Situational factors (homeless people's loss of identification documents, lack of transportation, inability to arrange for child care, inadequate personal hygiene); and
  - -- Perceptions of the characteristics of homeless people (negative expectations on the part of service deliverers).

* The pressures of their social and physical environments often cause homeless people to ignore or underestimate their need for health care services:
  - -- They often wait until a health condition is critical or life-threatening before seeking health care;
  - -- The emergency rooms of county hospitals and hospital districts are an expensive and often unsatisfactory means of handling their health problems; and
  - -- Homeless people find it difficult to comply with medical treatment regimes due to the lack of a regular residence and of a structured life style.

* For a homeless health care project to be effective, staff must be prepared to screen and refer homeless people to other social services (transitional housing, substance abuse treatment, job training, child care) and to be their advocates when problems of access arise.

(6) WHAT MODELS OF HOMELESS HEALTH CARE SERVICE DELIVERY WORK IN TEXAS?

With assistance from private foundations, local fund raising efforts and federal grants, several Texas cities developed model homeless health care projects which provide primary health care services and referrals to substance abuse treatment and mental health care.

* A multi-disciplinary health care team working in shelter-based clinics, and other sites accessible to homeless people, with a nurse practitioner being the primary service provider, can offer responsive, cost-effective services.

- Both the research literature and the results of these Texas projects document, however, that health care delivery systems have to adapt their procedures if homeless people's needs are to be met.
- Issues of accessibility and other barrier factors must be eliminated or reduced (location, hours of service, staff attitudes, waiver of eligibility requirements and fees, assistance with transportation, provision of on-site treatment and medications).

(7) WILL THE NUMBER OF HOMELESS INDIVIDUALS AND FAMILIES CONTINUE TO GROW IN TEXAS?

- Increasing problems: Many homeless service providers in Texas expressed deep concern about the possibility of continued increases in the homeless population, growing problems of drug abuse and violence in their communities, and the inability of social services to respond.
- Unemployable youth: Interviews also document homeless service providers' conviction that the high dropout rates of public schools and patterns of substance abuse and criminal involvement that frequently result generate many young people who are not employable.
- Mentally ill persons: Continued discharges of mentally ill patients from state hospitals into cities and rural areas which do not have sufficient community services to assist them makes it probable that many of these extremely vulnerable individuals will become homeless and victimized.
- Women, children, families: The growth in the number of homeless women with children and of two-parent families indicates an on-going economic and family disruption crisis in many areas.
- Unemployed men: A significant percentage of homeless men residing in Texas emergency shelters appear to have the background (high school completion, military service, a self-perception of being able to work) that should allow them to find work, yet most are unemployed.

(8) WHAT SHOULD BE THE ROLE OF GOVERNMENT OR THE PUBLIC SECTOR?

- This research project confirms a growing consensus in Texas that the public sector must assume greater responsibility for providing health care coverage and other support services to homeless people.
  - Texas decision-makers identified the federal government and the State of Texas as the bodies with the major responsibility for funding homeless health care services; city and county governments were ranked as the next level of major funders.
- Health care is viewed by direct service providers as an essential element in helping to stabilize homeless people and thus to help them to find employment and move toward greater independence.
- How such services will be incorporated into indigent health care services, whether at the county or the state level, is a major policy issue to be resolved by Texas citizens and their state legislators.

(9) HOW CAN WE INVEST IN OUR YOUNG PEOPLE TO PREVENT HOMELESSNESS?

- Many homeless advocates and homeless people insist that their most important needs are employment, job training and affordable housing, and that our public or tax revenues should concentrate on these areas.
- Local decision-makers throughout Texas identified the major unmet needs of affordable housing, education and employment as issues which should be addressed by the federal government and the Texas Legislature.
- Individuals in the private sector, both business people and community service volunteers, argue that Texas must invest more resources into its people now, especially its children and adolescents:
  - By spending our tax revenues, as well as our charitable dollars, on the education and health care of our young people;
  - By ensuring that our communities have excellent,

equitable **schools** and institutions of higher education;

-- By restoring, developing and maintaining adequate supplies of safe and sanitary affordable **housing**; and

-- By generating different sources of quality, low-cost **child care**; we will stimulate our local economies and tax bases.

* Only in this way can we begin to reduce the funds necessary for the maintenance of a constantly expanding penal system and what appears to be an increasing pool of substance abusers and severely mentally ill people. Such a human capital investment effort -- primary health care, affordable housing, quality public education and job creation -- will help to alleviate the pain of individuals who are homeless now and to prevent the homelessness of other Texas families in the future.

Acknowledgments by the Author

I would like to express my appreciation to the numerous individuals who supported the efforts of the Benedictine Health Resource Center and the author in realizing this research project. The state agency liaison people were especially helpful: Bryan Sperry, the former Family Health Resources Administrator at the Texas Department of Human Services, conceptualized the project, Ernie Schmid and Carl Volpe worked with us in the implementation, and Eric Fredlund assisted with the data analysis. The project Advisory Group members kept us connected to the cruel realities of homelessness, and they provided a constant reminder that the research findings had to make a difference. Don Bauman contributed extra time to the data analysis. Lt. Governor William P. Hobby's support of the survey was a boost in ensuring a good respondent return rate.

Rebecca Lewis and Chris Graham helped with the design of the literature review process, data organization and preliminary analyses. Susan Gonzalez Baker did all of that and more, offering her knowledge of homeless issues and extensive research experience, as well as helping with the data analysis and interpretation. Sheila Schell endured endless revisions of the report with good humor and professionalism.

A special note of recognition goes to the secondary students, paid and volunteer, who provided back-up services in data preparation, particularly Martin Miller who worked extensively with the graphs, tables, and bibliography. Marisa Andrade, Denise Kelker-Newlan, Feliz Fuentes and Carlos Andrade helped with the survey mailout, coding and other project tasks.

Sister Mary Sapp and the Board of the Benedictine Health Resource Center represent an unusual resource for Texas, and all of us are enriched by their vision of social policy research and activism to extend the availability of health care. Kent Miller is identified as the Project Administrator, but he played so many roles -- initiating the project, providing technical support, doing site visit interviews, working with layouts, reviewing early drafts, and clarifying the implications of the findings -- that he deserves special commendation.

Finally, I want to acknowledge the enormous debt that I owe to the many homeless advocates, health care providers, social service workers, community leaders and especially shelter administrators who interrupted their demanding schedules to orient me to their communities. They responded patiently and thoughtfully to what sometimes seemed like obvious questions, and they struggled to identify and prioritize what must be done so that homeless people can escape from their living hell in our communities.

I thank you all, while noting that the views expressed here, as well as the limitations of the report, are mine and that they do not necessarily reflect the policies or perspectives of the sponsoring agencies or the Benedictine Health Resource Center.

INTRODUCTION

Due to expressed concern about health care access problems of homeless people by Robert Mosbacher, Member of the Board of the Texas Department of Human Services (TDHS), the agency determined to sponsor a needs assessment study on homeless health care in our state. TDHS staff approached the Benedictine Health Resource Center about the possibility of coordinating such an effort, and, once the goals were clarified, the Center assumed responsibility for the research. Preliminary work with the literature required contacting other State agencies for information. As a result, the administration of the Texas Commission on Alcohol and Drug Abuse (TCADA) became interested in the project and asked the Benedictine Center to expand the scope and to focus more intensely on substance abuse issues, thereby becoming a co-sponsor. Both agencies hoped to obtain basic planning information which would allow them to determine if they should develop new initiatives to serve homeless people in Texas more effectively.

Center staff worked with state agency liaison people in the development of five major objectives:

1. Clarify issues related to definitions of "the homeless" and the policy implications of using different methods for estimating the size of the homeless population;

2. Investigate existing data and perceptions of key service providers regarding need indicators for health care services to homeless people, including demographic characteristics of the homeless and their distribution in Texas;

3. Identify issues related to policy decisions about allocation of public resources to complement current services of both local governments and private organizations to provide appropriate and comprehensive health care for homeless in Texas;

4. Investigate existing data and perceptions of key service providers regarding local health care initiatives in Texas and the capacity of local governments and private organizations to meet future health care needs of the homeless; and

5. Describe the areas where the additional collection of information is required to address key policy questions concerning an assessment of any potential role by TDHS or TCADA in bridging gaps in health care services for homeless people.

The research process included working with staff of TDHS and TCADA to ensure that the project targeted appropriate policy concerns and service delivery issues; the review of existing literature, both catalogued and unpublished; the design of a field research component that used several types of interviews and survey techniques to supplement findings from the literature review; and the formation of a homeless service provider advisory group which assisted in the design and interpretation of the field research effort.

Because of the Benedictine Center's goal to assist communities in seeking new ways to promote adequate health care, the Center was challenged by this project. Beginning in 1985, the State of Texas began to adopt Medicaid options which extend coverage for low-income populations beyond the minimum required by federal law. Health care advocates welcomed the 1988 expansion of Medicaid to cover additional pregnant women and young children. Yet we know that many Texans living in poverty still do not have health coverage. This report presents the results and outlines some of the major implications for homeless health care services in Texas. Through the dissemination of its findings, we hope to create a broader statewide awareness of homeless and indigent health care issues. The Benedictine Health Resource Center wants to express its appreciation to Mr. Mosbacher and the Texas Department of Human Services, as well as the Texas Commission on Alcohol and Drug Abuse, for the opportunity to have participated in this important project. We hope that the report will challenge all of us, in both the public and the private sectors, to work together to help these needy Texans to move out of crisis situations and into more stable, productive lives.

Sister Mary Sapp
Executive Director
Benedictine Health Resource Center

August 1, 1988

Chapter I

AN OVERVIEW OF HOMELESSNESS IN THE UNITED STATES

> *A tattered appearance, bizarre behavior, belongings carried in plastic bags or cardboard boxes tied with string, swollen ulcerated legs or apparent aimlessness: these are the obvious features which distinguish the homeless from other pedestrians and travelers. But there are also those who have been able to maintain a reasonably good personal appearance and whose behavior betrays no apparent sign of disorder and they are often overlooked by casual observation.*
>
> Baxter & Hopper, 1981

> *Homeless women and children are particularly vulnerable. They are fragile, defenseless and easily victimized. They are beaten, robbed and raped daily. They are easy prey for violence, disease and prostitution. They usually have no safe place to go to.*
>
> Farr, 1985

LIVING IN THE GRAY ZONE

An analysis of homeless health care issues must begin with a review of historical variations in our society's perception of "the homeless," as well as how the characteristics of homeless people have changed over time and in different regions of the United States. Much of the conflict about services to homeless people emerges from differing perceptions of what defines homelessness. The lack of clear definitions complicates research efforts to count and describe homeless people, frequently resulting in apparently contradictory results and incomplete information for service delivery planning.

A. HISTORICAL CONTEXT OF "THE HOMELESS" AND CHANGING DEMOGRAPHIC TRENDS OF THE 1980'S

A recent historical review of homelessness in the United States outlines major "waves" of homeless people in this country and how our citizens responded (Hopper & Hamberg, 1984). Attitudes from the 19th Century focused on the responsibilities of "Victorian charity" and donating to the poor. The "typical" homeless person was viewed as an older drunken man who lived in the street because he had lost his ties to work and home through the character flaw of alcoholism. Following the Great Depression, changing social and political attitudes led the U.S. Government to initiate a series of programs for job development and training, family assistance to children and the elderly, housing construction and financing, and a growing role in low-income health care which in time fostered a concept of "welfare rights". The authors argue that major policy changes by the federal government during the 1980's, coupled with economic setbacks and unemployment, undermined the social service support system that protected lower-income individuals from destitution and greatly increased the number of homeless people .

In the 1980s, homeless people in the United States increased, and their characteristics changed our view of the homeless individual as a Skid Row alcoholic:

LIVING IN THE GRAY ZONE

> *At no time since the great depression have the homeless poor represented so broad a cross-section of American Society as they do today.* (Hopper, 1983)

Studies from states as diverse as New York, Minnesota and Ohio and cities including New York, Washington, D.C., Minneapolis, Baltimore, Nashville, Los Angeles, and Phoenix, document several dramatic changes in the characteristics of homeless people in the United States. Several studies in emergency shelters conclude that as many as one third of their residents may be new to life on the streets, and the majority are natives or long-term residents of their areas rather than transients passing through. These homeless individuals are younger and include a growing percentage of women compared to previous patterns. The number of families, both women with children and two-parent families, seeking emergency shelter has startled many observers. Adolescents on their own, characterized as run-aways and "push-outs," hang out on the streets of many large cities. Preliminary data suggest that families of young women with teenagers or children may be the fastest growing group among the new homeless.

The homeless also include ethnically diverse groups, with more Black and Hispanic individuals than in the past, and some researchers project that young minority men will become one of the largest groups among homeless people in many areas. Veterans are represented in fairly large percentages, and some homeless people have educational credentials that should ensure them employment. In addition, many communities report significant percentages of deinstitutionalized individuals, such as former residents of state mental hospitals and criminal justice facilities, as well as young people who reach an age requiring that they be released from foster care or other publicly supported residences. One particular concern is the apparent increase in the number of chronic or severely mentally ill young adults among the homeless groups of many cities (Bachrach, 1984; Baxter & Hopper, 1981; Crystal, 1982; First, Roth & Arewa, 1988; Fischer et al., 1986; Fisher & Breakey, 1987; Flynn, 1985; Governor's Advisory Board, 1986; Holden, 1986; Kasinitz, 1984; League of Women Voters of Minnesota, 1984; Michigan Department of Mental Health, 1986; New York State Department of Social Services, 1984; Noble et al, 1985; Roth & Bean, 1986; Ropers, Robertson & Boyer, 1985; Stefl, 1987; Stoner, 1983; United Way, 1984; Wiegard, 1985).

The resulting dramatic increases in the number and diversity of homeless people on the streets of U.S. communities challenged local service providers and leaders to respond. In many cities, they formed local coalitions for the homeless, established new emergency shelters and food programs, expanded existing assistance efforts, and initiated a growing, often heated, dialogue over what services are actually needed by homeless people in this country.

For Texans to participate in this dialogue effectively, we must first make sure that we are talking about the same issues. What characteristics or circumstances determine that a person is homeless? To work together, we must be in agreement about our definitions so that we can identify the needs of people for assistance, their existing resources and backgrounds, the types of services available in our communities, and how we can best assist people to move out of their crisis situation toward a more stable and productive role in society.

B. DEFINITIONS OF HOMELESSNESS

Government officials, researchers, community leaders and social service providers use a variety of concepts and labels to describe different types of homeless people. Definitions range from the very broad:

> *a person who is poor and has no permanent residence* (Vanhorenbeck, 1987);
>
> *to be homeless implies the lack of a residence where one can sleep and get one's mail* (Ropers, Robertson & Boyer, 1985);

to the identification of very specific sleeping sites:

> . . . *those whose primary nighttime residence is either in the publicly or privately operated shelters or in the streets, in doorways, train stations and bus terminals, public plazas and parks, subways, abandoned buildings, loading docks and other well-hidden sites known only to their users.* (Baxter & Hopper, 1981, p. 7)

Other definitions focus on homeless types in terms of the time factor: 1) chronic, the typical homeless person of the past; 2) periodic, such as migrant and seasonal farm workers; 3) temporary, includes non-disruptive homelessness, such as moving or a hospital stay; and 4) total, for example, disaster victims or economic casualties (Rivlin, 1985).

Social science researchers have attempted to be more specific in their definitions of homeless groups. A carefully controlled study aiming to measure the size and demographic characteristics of homeless people in a major urban area defined the people to be interviewed as the "literally homeless" and those who were "marginally housed" (Rossi, Wright, Fisher & Willis, 1987). Homelessness is also portrayed as a social condition. A major effort to estimate the size of the homeless population in Texas defined them as urban street people, with a lifestyle characterized not only by the absence of permanent housing, but also of by the lack of supportive familial bonds and consensually defined roles of social utility and moral work (Baker & Snow, in press). Research focusing specifically on social service delivery issues often divides homeless people into groups based on their needs, e.g., the severely and chronically mentally ill, substance abusers, and others with no major health problem whose major concern is finding employment (Farr, Koegel & Burnam, 1986).

Governmental studies have offered other approaches to the definition of homeless individuals. A major statewide research study sponsored by the Ohio Department of Mental Health categorized homeless people into street people, shelter residents and resource people, i.e., those who stayed in inexpensive motels or with family and friends for short periods of time (Roth & Bean, 1986). A report on housing problems in Texas discussed different groups of homeless people in terms of different causes for their circumstances: the mentally ill, ex-offenders, the recently unemployed, people from low income families who had limited educational and employment opportunities, and the chemically addicted (TDCA Task Force on Affordable Housing, 1987).

Local social service programs attempt to draw from these studies to organize their information collection procedures in order to plan their assistance efforts. For example, a California city task force identified five major target groups of homeless people for assistance:

A. Transients/Temporary Residents;
B. Mentally and Physically Disabled;
C. Substance Abusers;
D. Elderly and Other Downtown Residents; and
E. Vagrants (aggressive and clandestine).

In contrast, one Texas program identified three types of homeless people:

Type I- Temporary Homeless (due to loss of employment or illness, family breakup, natural disaster, medical care, but also including runaway youth and the "voluntary homeless");

Type II- Chronically Mentally Ill (characterized as in and out of shelters, with unstable family or personal relationships and including substance abusers); and

Type III- Long-term Economically Disadvantaged (transient, non-resident and resident).

As suggested by these different approaches, a person may be defined as homeless based on the place where he or she sleeps at night, by a diagnosed medical condition, or by the degree of risk that he or she may run of being evicted from temporary housing. The duration of homelessness must also be considered. Some individuals have been on the streets for many years and accommodated themselves to that harsh lifestyle, whereas others are there for the first time, and still others have brief but regular episodes without a stable residence.

Thus, homelessness is not defined so much by a person's sleeping on the street or having to go to a shelter. An individual may flow in and out of homelessness depending on her or his resources -- staying with relatives or friends until their patience wears thin, going to a shelter until a temporary job or a government assistance check permits one to rent a motel room, living in the car until it becomes necessary to ask for help at a shelter.

In 1987, the federal government responded to this confusion of categories and methodological problems by defining a homeless person in rather broad terms and using a more inclusive criteria for providing services. The definition of a homeless person in the Stewart B. McKinney Homeless Assistance Act is:

> *(i) an individual who lacks a fixed, regular, and adequate night time residence; and/or*
>
> *(ii) an individual who has a primary nighttime residence that is:*
>
> *(a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);*
>
> *(b) an institution that provides a temporary residence for individuals intended to be institutionalized; or*
>
> *(c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.*
> (U. S. House of Representatives, 1987)

Therefore, all of the following could be described as homeless people: a mother and her children at a center for battered women, a veteran sleeping under a bridge, two parents and their baby living in an automobile, a pregnant adolescent sleeping on the sofa of her sister-in-law's apartment, a prisoner about to be released on parole, and an elderly couple faced with eviction in six weeks. The federal definition of a homeless person thus provides the foundation for both future research and for provision of services. While such an inclusive definition demands complex planning efforts by service providers, it nevertheless reflects an unavoidable reality. Homeless people vary in their characteristics and the conditions which engendered their homelessness, and they will require a diverse range of services to help them out of their crisis situations.

C. METHODOLOGICAL PROBLEMS IN COUNTING HOMELESS PEOPLE

As a result of the foregoing issues, attempts to count homeless people and to provide an exact estimate of the number of homeless individuals in a community face serious problems. Harsh criticisms of publicly sponsored research, such as the federal HUD report (U.S. Department Housing and Urban Development, 1984), relate to the lack of awareness on the part of government officials and social science researchers about the realities of life on the street:

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> *The simple fact of the matter is that there is no way of estimating the numbers of a fugitive, reclusive population which has everything to be lost in being counted and nothing to be gained.* (Hopper, 1984, p. 42)

Any count of shelter populations is an undercount because it ignores different types of people who live on the street or who have other temporary arrangements. Due to stigma and security concerns, people on the street often go to great pains to remain undetected. Counting procedures that concentrate on the downtown area tend to overlook major subgroups, such as women or adolescents, who may be found in other geographic areas (Wiegard, 1985). Furthermore, to estimate the number of marginally housed people who are living with relatives and friends or who are on the verge of eviction is extremely difficult,not to mention the homeless people in jails and hospitals (Hopper, 1984). Statistical projections from local city assessments and/or shelter operators lead to biased estimates that are undoubtedly too large. Attempts to tally "experts' responses" discount the homeless people who do not use or have access to the services of public and private agencies on which expert inferences are often based. Direct interviews with homeless people, while often useful for improving local services, can seldom be applied to national estimates because of problems of sampling, high refusal rates, the potentially inappropriate nature of self-administered or highly structured instruments, and the difficulty in developing sufficient levels of trust to obtain authentic responses (Applebaum, 1984; Bachrach, 1984; Ball & Havassy, 1984; Milburn, Watts & Anderson, 1984; Ropers, Robertson & Boyer, 1985).

Given the lack of consensus in the past about the definition of homelessness and the fact that most studies used different methods of counting individuals identified as homeless, policymakers are hard pressed to arrive at a commonly accepted estimate of the number of homeless people in the United States. Advocates for homeless people argue that at least one per cent of the national population is homeless at any given time (Hombs & Snyder, 1983). The widely discussed HUD report suggests a homelessness rate of 25 per 10,000 population in urban areas. An alternative estimate also issued by HUD proposes different rates of homelessness for different sized urban areas, e.g., 13 per 10,000 in large areas (one million or more population), 12 per 10,000 in medium areas (250,000 to one million population), and only 6.5 per 10,000 in small (25,000-250,000 inhabitants). Thus, depending on the method and estimate that one accepts, the number of homeless individuals in the United States can range from a low of 300,000 to a high of almost two million people (Baker & Snow, in press).

An irreverent reporter's reaction to the HUD report summarizes much of the frustration that health care providers and other social service workers feel about such quantitative approaches in their perception that *"the homeless are becoming the most overstudied and underserved group in America:"*

> *If only the homeless poor were polar bears or bald eagles, the Census Bureau could staple radio-active bands to their hides, and keep accurate counts of them, no matter where they roamed or flew.*
>
> *Once tracked to the Bowery of New York City, a banded homeless person would not be double-counted if he migrated south to the Skid Row of Miami. The numbers would not get out of hand. Nor the problem.* (McCarthy, 1984)

D. SUMMARY

The characteristics of the "new" homeless forced all of U.S. society to look at homeless issues with renewed commitment and greater objectivity. The media's growing awareness of homeless concerns due to the recent emphasis on research and analysis efforts at the community level undoubtedly helped to stimulate a national response to the needs of homeless people. In addition, as social ~~service program~~ administrators became more aware of homeless people, they modified their data collection processes in order to identify homeless clients and to follow them through the service delivery system (Kline et al., 1987). But homeless advocates argue that planning processes should not be stymied due to the lack of methodologically perfect enumeration processes:

> *Whether you are talking about one fourth of a million people or a million or 2 million, it is irrelevant, because the gap between the need and availability is so huge.* (McCarthy, 1984)

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One of the key problems faced by health care planners and providers who want to adapt services to the needs of homeless patients has been the lack of medical data (other than alcohol studies). Several recent clinical and field studies have clarified and broadened our understanding of homeless health care problems. Chapter II summarizes their findings.

Chapter II

HEALTH CARE NEEDS OF HOMELESS PEOPLE IN THE UNITED STATES

> *Thus the data suggest that poor health is not a random phenomenon among the homeless, and the hierarchy among demographics and social variables underlines the major contribution of unemployment to poor health. Homeless persons interviewed indicated that their financial situations had precipitated their poor health and not the inverse.*
>
> Ropers, 1987

> *Quotation from a men's shelter director: I think mental illness needs to be treated the same way as physical illness. We don't see a person with a broken arm and think he did it to himself. We feel sorry for him because he's got a broken arm. Medical science hasn't figured out how to treat mental illness for the most part. And while we're trying to figure that out, we shouldn't be treating these people like a subclass.*
>
> Meagher, 1986

A growing body of research and clinical studies documents the primary health care problems and needs of homeless people. The existence of health care services, however, does not necessarily mean that the homeless will have access to medical care. Growing awareness of homeless people's health risks and recognition of society's responsibility to assist them resulted in several new initiatives in the 1980's from both the private sector and the federal government.

A. HEALTH CARE PROBLEMS OF HOMELESS PEOPLE

Most local advocates for homeless people argue passionately that the immediate needs of homeless people for emergency shelter and food must be met before other issues can be addressed: people in profound crisis cannot focus on health screening, job searches, literacy, personal hygiene, etc. Thus, these advocates believe that the first health care priority is to develop and maintain safe, clean and orderly shelters that provide regular, nutritious meals to people with a minimum of emphasis on eligibility criteria. Beyond this minimum sustenance level, however, there are major categories of health care problems faced by homeless people. For example, one study of homeless "individuals" in a major metropolitan area documented that 28% of the people interviewed said that they had some health problem which prevented them from working (Rossi et al., 1987). The health care categories are outlined below in terms of the traditional health care delivery system in order to reflect on where services to meet the needs of homeless people are available.

(1) **PRIMARY HEALTH CARE** - The readily apparent health care needs of homeless people result from the impact of the environment and their inability to take care of themselves due to the lack of a domicile and basic resources. Thus, the effects of exposure, whether from severely cold and/or hot weather, infestations and insect bites, lack of sleep, over time generate illnesses and systemic disabilities that become more serious if they go untreated. Their lack of access to simple medicinal remedies maintained in most households or available for purchase in local

pharmacies or grocery scores creates serious problems, because conditions that begin as fairly minor problems generally escalate into major infections due to lack of treatment.

Studies on homeless health care identify the primary acute and chronic conditions (Bassuk, Rubin & Lauriat, 1986; Brickner, 1985; Kellogg et al., 1985; Kelly, 1985; McAdam et al., 1985; Michigan Department of Mental Health, 1986; New York State Department of Social Services, 1984; Noble et al., 1985; Ropers, Robertson & Boyer, 1985; Rosenheck et al., 1987; Roth et al., 1985; Roth & Bean, 1986; Surber et al., 1988; Wright & Weber, 1988). Among other important findings, these studies document the demographic changes in the homeless population outlined above and the necessity of looking at gender, race/ethnicity and age factors in relation to health conditions. For example, disabilities vary among homeless individuals living alone, who report more mental illness and substance abuse, and those homeless adults and children in families, who are more likely to be malnourished and/or victims of domestic violence (Ball & Havassy, 1984; Farr, 1985; New York State Department of Social Services, 1984; Special Report, 1983; Stoner, 1983). In addition, some observers believe that health problems, both physical and emotional, are disproportionately affecting children, due not only to conditions in the streets but safety conditions in emergency shelters (Kozol, 1988).

The most recent comprehensive study on homeless health care concludes that acute problems account for about two thirds of the primary needs and chronic problems about one third, a pattern very similar to that of a regular ambulatory medical practice (Wright & Weber, 1988).

Acute health problems consist mainly of:

- upper respiratory infections;
- traumas (lacerations and wounds, sprains, bruises and fractures), which tend to be more common among men and younger homeless people;
- nutritional deficiencies (mainly malnutrition and vitamin deficiencies), which tend to be more common among women and Whites and also tend to increase with age; and
- infestations and more serious skin ailments.

Chronic health problems generally include:

- hypertension, more frequently for men and for non-Whites;

- gastrointestinal problems (ulcers, colitis, hernias);
- peripheral vascular disease, "*the characteristic chronic physical disorder associated with a homeless existence*" (gout, varicose veins, phlebitis, edema, thrombosis, gangrene and others), which are somewhat more common among men and Whites and which increase with age and often result from a homeless life style (constant and forced walking, the need to sleep sitting up);
- serious dental problems, usually resulting from neglect and often leading to extractions;
- neurological disorders (migraine headaches, neuritis, more serious illnesses such as Parkinson's disease and a variety of seizures);
- other chronic disorders (anemia, ear disorders, liver disease, and genito-urinary problems); and
- pregnancy among homeless women.

The major conclusions to be derived from this research and the others cited are that homeless people suffer from most chronic physical disorders at an exceptionally high rate and that their illness and death rates are very high, even for treatable conditions, due to their lack of access to care. For example, the rate of tuberculosis is conservatively estimated to be at least 25 times higher than that of the urban population generally (Surber et al., 1988; Wright & Weber, 1988). Other studies of a more local nature or which focus on specific health care disorders support this description (American Psychiatric Association Task Force, 1984; Bachrach, 1984; Chailkin, 1985; Coalition for the Homeless, 1984; Filice et al., 1984; Kelly, 1985; Lipton, Sabatini & Katz, 1983; Morse et al., 1986; Ropers & Boyer, 1987; Shandler & Shipley, 1987; Task Force on Emergency Shelter, 1983; United Way of America, 1984).

(2) **CHILDREN AND ADOLESCENTS** - The limited research on homeless children and adolescents describes the seriousness of their health risks and their lack of access to general pediatric and preventive health care. A comparison between children and youth in a national medical survey with clients ages 15 and younger in a homeless health care project documents dramatic differences between the two groups (Wright & Weber, 1988). The pattern of illness is essentially the same, but rates of occurrence among

homeless children and teenagers are much higher. For example, upper respiratory infections and serious skin disorders were twice as high, and nearly 2% of the homeless children suffered from nutritional deficiencies, which were virtually non-existent among children in general. About 16% of the homeless children were diagnosed as having at least one chronic health condition. Rates of anemia and of eye and ear disorders were almost twice as high, while dental problems were 10 times as common. Homeless children were four times more likely to have gastro-intestinal disorders. Nearly 4% of the girls age 15 and younger had been pregnant, while 2.4% had contacted some type of sexually transmitted disease.

(3) **MENTAL HEALTH SERVICES** - Attempts to study the mental illness and substance abuse rates of homeless people must assess both the impact of social stigma and health care providers' ability and willingness to detect such disorders. Many homeless people are reluctant to participate in structured activities; such social distrust is often even more exacerbated in former mental patients and substance abusers. Underdiagnosis of both disorders by health care professionals is acknowledged as a wellknown problem. Therefore, almost any research on these topics results in some type of underestimation, considering refusal rates and a natural tendency by respondents to deny such problems (Kroll et al., 1986; Wright & Weber, 1988).

Several authors emphasize the futility in focusing too heavily on causality links between mental illness and homelessness. Being homeless in itself can give rise to behaviors that are considered pathological and indeed may actually be positive coping behavior in terms of surviving on the street (Baxter & Hopper, 1981; Levy & Henley, 1985; Michigan Department of Mental Health, 1986; Wright & Weber, 1988). The fact that there is no universally accepted definition of the characteristics of mental illness point once again to the importance of who defines "appropriate" versus "inappropriate" behavior. As a homeless person in New York City summed it up:

> *Half the people I know are suffering from chest infections or sleep deprivation. The lack of sleep leaves you debilitated, shaky. You exaggerate your fears. If a psychiatrist came along, he'd say I was crazy. But I was an ordinary man.*

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> *There was nothing wrong with me. I lost my wife. I lost my kids. I lost my home. Now, would you say that I was crazy if I told you I was feeling sad?* (Kozol, 1988, p. 62)

Published estimates of mental illness among the homeless population in this country range, due to the use of different diagnostic criteria and measurement procedures, from lows of 15% to highs of 90% (Bassuk, 1984; Farr, Koegel & Burnam, 1986; Michigan Department of Mental Health, 1986; Morse et al., 1986). A major trend appears to be the growing number of severely mentally disabled homeless persons between the ages of 18 and 35, who are being categorized somewhat contradictorily as "young adult chronics" (Kellerman et al., 1985). Furthermore, most research suggests that homeless women are more seriously ill than men (Stefl, 1987). A national study of homeless health care identifies nearly 20% of the patients as having some signs of emotional problems or psychiatric impairment and, taking other measures into consideration, suggested a rate of about 33% as an accurate estimate of mental illness among the adults in that sample. The authors conclude that about a third of the homeless have significant psychiatric impairments, with at least half of those individuals being severely mentally ill, and mental illness was more common among older White/Anglo women than other groups and lowest among Hispanics (Wright & Weber, 1988).

Numerous studies have examined the impact of state deinstitutionalization policies on the severely mentally ill, in which thousands of residents of public psychiatric hospitals were released, theoretically with the goal of their obtaining more appropriate care in their communities (Deinstitutionalization Supportive Services Subcommittee, 1983; Farr, 1985; Flynn, 1985; Hombs & Snyder, 1983; Kanter, 1985; Lipton, Sabatini & Katz, 1983; Roth & Bean, 1986; Westermeyer, 1987). Almost all of the authors emphasize that the major need is for a variety of local transitional shelter and housing programs:

> . . . *the [mental health] service system presently offers few mental health services to these people that will make a difference in the quality of their lives, particularly in the absence of appropriate housing services.* (Kellerman et al., 1985, p. 186)

Thus, many advocates for the homeless severely mentally ill argue for a restructuring of local mental health services to provide a continuum of care to be coordinated by case managers, which is based on living arrangements with varying degrees of supervision, ranging from 24-hour care to halfway houses and apartment cooperatives (Arce et al., 1983; Bassuk, 1984; City of Baltimore Health Department, 1986; Cohen, Putnam & Sullivan, 1984; Gittleman, 1985; Lamb, 1985).

(4) SUBSTANCE ABUSE SERVICES - In spite of the difficulties of generating a firm epidemiological rate of alcohol or drug use among homeless people, there are fairly clear indicators at least for the first. Historical research identifies a remarkably stable estimated rate of alcohol use and abuse among homeless people:

> *Despite the programs - ranging from neglect to salvation to incarceration to detox - that have been devised for the public inebriate, the percentage of alcoholics among the homeless has apparently hovered around the 30% [mark] for nearly a century.* (Stark, 1987, p. 12)

While local studies which do not always use clear definitions and measures of abuse may report much higher rates, recent more systematic research on homeless health care supports this estimate (Fischer & Breakey, 1987; Lubran, 1987; Mulkern & Spence, 1984; Phoenix South Community Mental Health Center, 1983; Roth & Bean, 1986; Shandler & Shipley, 1987; Wright, A., 1985; Wright, James., 1985; Wright et al., 1987; Wright & Weber, 1988). Several analyses suggest that polydrug use is the fastest growing substance abuse problem among young homeless people (Shipley et al., 1985).

A national homeless health care research project concludes definitively that, *"alcohol and drug abuse are leading health problems among homeless people,"* suggesting that roughly one half of the men and one sixth of the women are alcohol abusers and that about 13% of both groups abuse drugs. The authors also note that both groups of abusers suffer most physical disorders at a considerably higher rate than other homeless people. The same study mentions that measurable numbers of alcohol problems were identified for homeless children as young as six to ten in their program and that teenage alcohol abuse signs were evident in about 8% of the girls and 10% of the boys (Wright & Weber, 1988).

(5) DUAL DIAGNOSIS - The problem of dual and multiple diagnoses presents an unusual challenge to homeless health care providers. For example, research studies suggest that 12% to 60% of homeless people are both mentally ill and substance abusers (Farr, Koegel & Burnam, 1986; Surber et al., 1988), and there is a major gap in services to meet their needs (Lucas County, 1986). For example, preliminary research on homeless chronically mentally ill veterans found that 85% of the patients in a national program had at least one indicator of serious alcohol, drug or mental illness problems, while 64% had been hospitalized at some time in the past for an alcohol, drug or psychiatric illness (Rosenheck et al., 1987).

A national study of homeless health care proposes that perhaps 25% of homeless people suffer from some combination of alcohol, drug and mental illness problems. There are also different demographic patterns in terms of co-occurrence; for example, although homeless women abuse alcohol much less frequently than men, women alcoholics are much more likely to be multiply disabled. In general, the authors report that half or more of the homeless who abuse drugs also abuse alcohol, and mentally ill persons of both genders abuse alcohol and drugs at higher rates than the other homeless people in the sample (Wright & Weber, 1988). Many homeless shelters have admissions policies which restrict the entrance of physically and mentally disabled individuals, substance abusers or people with multiple problems (New York State Department of Social Services, 1984); thus, such multiple disabled persons face difficult barriers in gaining access to health care.

Several observers of mental health and substance abuse service delivery systems argue that not even patients with insurance or other private resources have access to treatment facilities which can address the complexities of their multiple disabilities of mental illness and substance abuse, or other patterns which might also include mental retardation, epilepsy, pregnancy, diabetes, visual or hearing handicaps. Facilities often use admissions criteria which exclude such individuals from treatment (e.g., a mentally ill substance abuser, a hearing disabled mentally ill person, a pregnant woman who is a substance abuser). The probability of a multiply disabled homeless person accessing a treatment program of such programmatic sophistication, thus, is frankly almost non-existent (Levy & Henley, 1985; Wright & Weber, 1988).

(6) REPRODUCTIVE HEALTH SERVICES- Sexual assault is one of the major problems faced by most homeless women on the street, and many homeless women and adolescents are forced to rely on offering their sexual services in order to survive on the street (Ball & Havassy, 1984; Farr, 1985; Special Report, 1983; Stoner, 1983). Yet pregnancy, contraception and sexually transmitted diseases are health care problems less frequently discussed than other primary care topics in the homeless health care literature. This may be an artifact of the tendency to study shelterbased homeless people and the fact that up until recently fewer women used such shelters and/or those in residence tended to be older and less at risk of pregnancy.

On the other hand, it may be related to researcher and provider attitudes about sexuality. For example, the authors of one study deal very sensitively with the high rates of poor dental hygiene by noting that given the lack of a stable residence, where are homeless people to keep their toothpaste and brushes? On the same page, however, they report the "surprisingly high" rate of pregnancy among homeless women in the sample. One is led to ask in a similar fashion, that lacking a stable residence, where are the women to keep their pills and condoms to protect themselves from unwanted pregnancies?

A national research study reports that almost 10% of all adult women seen were pregnant at or since their first contact with the demonstration projects. Young women aged 16 to 24 years old, however, had much higher pregnancy rate (about 23%). There were no significant differences between White women and women of color in any age group. The incidence of sexually transmitted diseases (STDs) were approximately equal to those of the population at large, with STDs being more common among women at all ages and more common among the young regardless of gender (Wright & Weber, 1988). Given the rates of alcohol and substance abuse among homeless women in these demonstration projects, it can be seen that many babies are at risk of fetal distress yet the availability of treatment programs for the women is limited.

(7) **AIDS** - The homeless health care literature does not address AIDS. Research findings on AIDS or ARC infection in the same national homeless health care study are so preliminary and the number of cases too few as to make conclusions difficult. What may be relevant is the authors' suggestion that intravenous drug use is equally as significant as sexual contact in AIDS transmission among homeless men (Wright & Weber, 1988).

B. SERVICE DELIVERY ISSUES FOR HOMELESS HEALTH CARE

Research on homeless health care service delivery often focuses on two major issues: barriers which block access to services and the need for comprehensive services.

(1) BARRIERS TO HEALTH CARE FACED BY HOMELESS PEOPLE - Social science researchers suggest the importance of distinguishing between structural barriers and psychological or client perceptual barriers to homeless people's use of health care services (Baumann & Grigsby, 1988; Baumann et al., 1988).

Structural barriers - The first issue is whether or not health care services for indigent people are actually available in the community. In many rural areas, such services are non-existent unless some form of general assistance will purchase health care from private providers. In urban areas, the only primary care available to many homeless people may be services at the county hospital's emergency room. The refusal by suburban areas to permit the development of shelters or other services for the homeless represents another type of availability barrier (Lewis, 1986). An additional factor is whether or not homeless people are aware of the services. The use of aggressive outreach programs to inform homeless individuals about available health care programs can make a significant difference (Cohen et al., 1984).

A different structural barrier relates to whether or not health care services are accessible to the homeless. The location of a clinic in relation to concentrations of homeless people and public transportation networks, the cost and complexity of using public transportation, clinic hours of operation, the presence of bilingual receptionists and health care providers, provision of child care, accessibility for the physically handicapped -- all represent potential barriers to homeless individuals in need of health care services. Long waiting periods and complicated intake procedures serve as deterrents. Admissions criteria which limit services on the basis of categorical diagnoses also function as barriers; homeless people with multiple health and emotional problems are often refused services because of the complexity of their condition (Levy & Henley, 1985; New York State Department of Social Services, 1984). Referring homeless people to clinic services in other locations or to pharmacies at other sites to obtain prescribed medications also generates additional barriers (Chailkin, 1985). Screening programs which ignore the fact that the cost of prescribed medications, eyeglasses, hearing aids or dentures makes them unaccessible to most homeless patients are fostering barriers to health care (Scheibel, Mertz & Rettman, 1982).

A third barrier to homeless people's use of health care services relates to the potential clients' judgments about whether services are acceptable. The major factor seems to be that of staff attitudes and their reactions to the often unpleasant effects of life on the street and living in shelters. Homeless patients' inability to have regular access to bathroom facilities and laundries results in their appearing disheveled and dirty. The stress of homelessness often makes people defensive, fearful and acting out aggressively to protect themselves from being victimized. Many health care providers and social service workers are reluctant to deal with dirty, bizarre individuals, and such reactions tend to offend or scare homeless clients away (Breakey, 1987). Even when a homeless project health care provider learns how to act non-judgmentally, referral of a client to another site becomes problematic (Surber et al., 1988). In addition, many service providers tend to underestimate the external difficulties encountered by homeless people and end up "blaming the victim" if a homeless patient does not follow through with prescribed medication or fails to show up for an appointment (Breakey, 1987).

A fourth structural barrier can emerge in terms of the health care service delivery and its willingness to become accountable for homeless health care. This implies that the system's emphasis on quality control will incorporate elements of concern related to homeless clients. Therefore, clinic statistics will be maintained and routinely analyzed to track homeless patients through the system, staff will receive regular inservice training on appropriate homeless heath care issues and service delivery strategies to meet the needs of homeless clients, and, whenever possible, input will be sought from homeless individuals about their priorities and for suggestions on how to improve service delivery, including the possibility of using former homeless patients as outreach team members (Breakey, 1987; McAdam et al., 1985).

Homeless Client Attitudal Barriers - Homeless people's perceptions of their health care or their psychological state also influence whether or not they seek out and use health care services. Many homeless individuals generally underestimate the seriousness of their health care problems (Farr et al., 1986; Fisher et al., 1986; Phoenix South Community Mental Health Center, 1983; Ropers & Boyer, 1987; Roth et al., 1985). In addition, the more time they have spent on the streets and the more homeless friends they have made, the more likely they are to underestimate or deny their physical, mental and alcohol problems (Baumann et al., 1988). Many homeless people are suspicious and frightened of interacting with social service providers, law enforcement officials and other community agency personnel. For example, women may remain in abusive situations rather than risk homelessness (League of Women Voters, 1984), and they often hesitate to ask for help fearing that their children will be taken away from them. The disaffiliation, frustration and hopelessness of homeless people about their situation often result in low motivation and poor compliance with treatment regimes. To develop relationships of trust and to encourage the participation of homeless individuals in a health care delivery system requires considerable patience, empathy and practical support (Bachrach, 1984; Breakey, 1987).

(2) THE NEED FOR COMPREHENSIVE SERVICES - Thus, in spite of data which document the extensiveness and severity of health problems among homeless people, many individuals living in emergency shelters and on the street do not identify health problems as their major concern or immediate priority. A more typical response is that found in a study of residents in 14 shelters in a major East Coast urban area. When the homeless people who participated were asked open-ended questions about what their greatest need was, *"The most frequent response within this category related to the desire to get a job, to be trained for a job, or for help in getting a job"* (Chailkin, 1985).

Yet most health care delivery systems are not set up to assist with such employment or social service efforts, and they are further splintered in terms of services for primary care, mental health services and substance abuse treatment. This makes it even more difficult for distrustful homeless individuals to use the system effectively. In another community, the researchers also found that in relation to mental health care,

> *Paradoxically, . . . what the homeless most wanted -- community support services of residential, case management and day program services -- were what they were least likely to receive; conversely, those services that they were least interested in -- medication and counseling -- were those most likely to be provided.* (Morse et al., 1986, p. 47)

A study of self-identified repeated users of psychiatric emergency and inpatient services in a major urban hospital reports a serious mismatch between the kinds of services that community mental health systems traditionally provide and the kinds of services which that group of homeless people feel they need -- e.g., affordable housing and financial assistance. Efforts to provide the psychiatric services available only add to the patients' skepticism and distrust, while staff begin to feel more and more manipulated by homeless people whom they view as system abusers (Ball & Havassy, 1984). Furthermore, it is totally unfeasible to offer outpatient care to chronic alcoholics if no housing is available to support sobriety (Shandler & Shipley, 1987). While such complaints are typical of mental health systems, they also characterize the reactions of homeless people to other health care programs.

Many existing health care delivery systems thus treat what's "wrong" with a homeless person, whether it's a physical or mental condition, before they acknowledge the need to find him or her some kind of housing. In the view of numerous homeless advocates, this places an unnecessary block between the homeless person and a safe place to live -- and it often results in a non-compliant or non-returning health care client. The proposed alternative is to support programs which provide both personal health care services and housing referral and placement at the same site and point of contact, even to the degree of generating housing development or working with local business people to develop alternative community referral models (Friedner & Arch, 1987; Korenbaum & Burney, 1987; Mayor's Task Force on Downtown Alcoholism, 1985; Newton & Duffy, 1987).

This also requires assisting homeless persons to become eligible for other social service entitlement programs and to begin working with them toward realistic employment alternatives. Initiating services with how patients view their situation and their identification of immediate needs will be a more effective way to influence the patients' view regarding the acceptability of the health care services being offered. Essentially, homeless health care researchers believe that integrated community care has failed and the coordination of services must be revived in order to serve this at-risk population (Brickner, 1985; Wright & Weber, 1988).

C. HEALTH CARE RESPONSES FROM THE PRIVATE SECTOR AND THE FEDERAL GOVERNMENT

FOUNDATION DEMONSTRATION GRANTS - In March 1984, the Robert Wood Johnson Foundation and the Pew Memorial Trust, in conjunction with the United States Conference of Mayors, announced grants totaling $25 million to establish Health Care for the Homeless demonstration projects. After soliciting applications from the 51 most populated cities in the nation, the two foundations received 46 proposals, which resulted in a total of 19 funded projects throughout the country. The following overview is summarized from preliminary research on the project, which also generated important data on homeless health indicators and service delivery factors (Wright & Weber, 1988).

The application guidelines reflect four important features of the local demonstration projects. First, the emphasis was on a strong community-based health care orientation. Second, proposals had to develop through a coalition process, including participation of local homeless advocates, local health care institutions, and city and state governments. Third, accessing a broad range of social services and benefits was identified as important as providing primary health care, and a major goal was to "mainstream" homeless people into the social and medical services for which they were eligible. Fourth, stimulating community advocacy for homeless people and homelessness issues was an additional goal.

There are several commonalities among the demonstration projects, including the administrative role of a local board of governance and a project director to manage implementation. Every project also uses a multidisciplinary health team (doctors, nurses and social workers), and all sites have a common numerical goal of serving at least 1,500 homeless people each year. None of the initial Johnson-Pew projects focused much on mental health, as the funding agencies had not emphasized that area. Within a year or so of operation, however, almost all sites began to develop a mental health component.

Important programmatic and design variations in the demonstration projects, however, indicate how local factors affect homeless people and the kinds of programs which assist them:

(1) degree of emphasis on mental health services;

(2) extent of dental and podiatry services;

(3) availability of staff from other public programs or unpaid volunteers;

(4) providing respite care for homeless patients as a leading problem in all projects;

(5) variation in the number and kind of sites for service delivery;

(6) referral arrangements to other health and social services facilities and agencies;

(7) degree of emphasis on alcoholism services;

(8) enormous variation in funding sources, and thus with reporting requirements, expectations and goals; and

(9) differences in local program structure, especially with respect to direct services versus subcontractual arrangements.

The Johnson/Pew national project funded one demonstration grant in Texas, the proposal submitted by the homeless coalition in San Antonio. It is discussed further in Chapter V.

GOVERNMENT GRANTS - The Stewart B. McKinney Homeless Assistance Act: The Urgent Relief for the Homeless Act, now PL 100-77 and known as the Stewart B. McKinney Homeless Assistance Act, became law in July 1987. Addressing both emergency and long-term approaches to the needs of homeless people, Congress authorized $442.7 million in FY1987 and more than

$616 million for FY1988. The McKinney Act includes programs in the following areas: community mental health services, primary health care, housing, emergency food and shelter, food assistance, veterans job training services, education, job training demonstration projects, and community services. The Act also established an Interagency Council on the Homeless with representatives from several federal agencies to assess programs at different governmental levels, and it also authorized studies on the impact of state deinstitutionalization policies on the homeless problem and on causes of adolescent homelessness (National Mental Health Association, 1987).

Six homeless primary health care projects in Texas received grant monies from the McKinney Act; they are described in Chapter V.

D. SUMMARY

Results from the first national study of homeless health care needs concludes that:

> *The leading health problem of the homeless is probably alcohol abuse, followed by mental disorders of various sorts . . . Most of the [physical health] patterns discussed . . . are the direct result of homelessness itself, not of correlated behavioral and demographic factors.* (Wright & Weber, 1988, p. 113)

Yet as numerous writers emphasize, many homeless people are either unaware of the extent of their need for health care, they are unable to focus on health care as a major priority in the face of their struggle to survive from day to day, or they lack access to health facilities where services could assist them.

One of the major goals of this policy research project was to clarify whether or not homeless people in Texas demonstrate a similar pattern in terms of their health care needs. The next chapter summarizes findings about homeless people in Texas and their health.

Chapter III

WHO ARE THE HOMELESS? WHAT ARE THEIR HEALTH PROBLEMS?

Emergency Room Director at a County Hospital in Texas: *"These people don't fit in anybody's box; they live in the gray zones of our health care delivery system. They're not mentally retarded enough, not psychotic enough, not dangerously alcoholic . . . At our hospital, we only have so much ER waiting room space. We only have so many ER holding beds for cases that need to be admitted to inpatient upstairs, and, of course, we're limited in the number of those beds. In all those slots, disoriented homeless people who have nowhere else to go are occupying space that should be used for new admissions. I try not to hassle them when we're not too busy, but the reality is that we're almost always too busy, and we end up having to ask the hospital guards to ease them out, back onto the streets."*

Andrade, 1988

The service system presently offers few mental health services to these people that will make a difference in the quality of their lives, particularly in the absence of appropriate housing services.

Kellerman, 1985

Recommended action by City Task Force on Homeless in Texas, 1987: *"Establish several shelters, each to provide services to special populations, i.e. mats for transients, cots for those seeking employment or job training, beds for those working 3 to 9 months. Cubicles of semi-private rooms for those employed steadily over 9 months."*

Andrade, 1988

LIVING IN THE GRAY ZONE

Texas, like many other states, discovered that homeless people increased in number and visibility during the 1980's, and they seemed to be different from past stereotypes of elderly alcoholic men in the street. While this was part of a national phenomenon, Texas suffered from some unique social and economic factors that generated considerable economic dislocation for many of its families. But few research studies on homeless people in Texas exist, and most of them concentrate on individuals in Austin. Several cities attempted to document the problems of homeless people in their communities, but the results vary in their quality and comprehensiveness. To supplement these somewhat limited findings, the Benedictine Health Resource Center implemented three research efforts to learn more about the health care needs of homeless people throughout Texas. The Center coordinated a census of emergency shelter residents, initiated an opinion survey of key community decision-makers, and undertook a series of field site visits to learn more about community needs and services for homeless people.

A. CHANGING SOCIAL AND ECONOMIC FACTORS IN TEXAS

The estimated population of Texas in 1988 was about 17 million people. This represents an increase of more than 21% from the 1980 Census population estimates. The number of poverty-level households in Texas also increased - by 42%, now one out of every five households in Texas. More than 18% of its inhabitants were below the poverty level, and almost 30% of Texans over 65 years of age have incomes below the poverty level. The number of single-parent families increased by 27.5%, and, primarily as a result of this demographic pattern, one out of every four Texas children is growing up in poverty. Research by the State Legislature documented the growing problem of hunger in Texas (Senate Interim Committee on Hunger and Nutrition, 1984). During a 12-month period of 1985-86, the number of unemployed persons increased by almost 44%, a reflection of the economic crises affecting petro-chemical businesses, farming and ranching communities, and computer industries in the state. A conservative estimate concluded that about 581,000 Texans have medically certified functional disabilities (Friedholm & Team, 1983).

Data from a 1985 Special Census indicated that 44% of Texans with incomes below poverty (1.2 million people) and another 1.5 million of Texans with above poverty incomes had no health insurance. Given the limited coverage of government medical programs, the authors projected that at least 53% of poor children and adolescents in Texas live in families with no health insurance and are unlikely to receive any regular health care. (Sperry & Volpe, 1987). In addition, Texas has an extraordinarily high rate of adolescent pregnancy, leading the nation in terms of girls aged 14 and under and ranking third nationally for girls aged 15 to 19. As an indicator of the problem's severity, in 1986, Texas paid out almost $19 million in AFDC benefits to teenage mothers and their children (Friedholm & Team, 1988; TDCA Task Force on Affordable Housing, 1987).

Such circumstances are strongly related to the inadequate education of many Texans. More than one third of adult Texans have not yet finished high school. But the school dropout figures are much worse for at-risk groups: 60% of those in poverty, 80% of recipients of Aid to Families with Dependent Children (AFDC), and 85% of the inmates in Texas prisons do not finish high school (Friedholm & Team, 1988).

A national study of 1980 Census data documents that Texas has one of the highest rates for undereducating its youth in the country: nearly 500,000 young people ages 16 to 24 were not enrolled in school and had not yet competed the 12th grade (Cardenas, Robledo & Waggoner, 1988). Another study on school dropouts in Texas reports a state dropout rate of about 33% - nearly one of every three Texas teenagers will leave school before obtaining a high school diploma. Hispanic and Black children and youth have much higher dropout rates of 45% and 34%. This is especially important, in that most estimates suggest that by the year 2000, Hispanic and Black children will be the majority in many Texas public schools. (Cardenas, Robledo & Supik, 1986).

Studies of individuals admitted to the Texas Department of Corrections document the outcome for many inmates. The majority of offenders are high school dropouts, who at the time of their arrest were unemployed and who do not have the marketable skills that would allow them to find and keep a job. Equally important, almost 80% of the offenders have serious alcohol and/or drug problems (Martinez, 1988).

These data help to explain why many observers of social services in Texas agree with analysts who conclude that, "*The safety net for poor people in Texas is among the weakest in the nation*" (Shapiro & Greenstein, 1988, p. 1). The eligibility guidelines for government assistance are very restrictive, and the levels of benefits granted are among the lowest in the nation. For example, the level of AFDC cash-assistance to single-parent families ranks 48th among the states and the District of Columbia. Texas does not provide AFDC benefits to two-parent families with children who are poor, and it also lacks a general cash assistance program for low-income single individuals or childless couples who are not elderly or disabled. Medicaid eligibility guidelines require a very low income status, and the State does not supplement the basic federal Social Security Income (SSI) grant to elderly and disabled individuals who are poor.

Finally, the State of Texas collects most of its tax money from sales taxes which constitute a heavy burden for low-income households, and it has a restrictive unemployment insurance program. The conclusion is that:

> *For unemployed two-parent families and their children who do not qualify for or have exhausted their unemployment benefits (as well as jobless single individuals and childless couples in this situation who are not elderly or disabled), little or no safety net exists. They are ineligible for virtually any cash assistance, regardless of how poor they may be. In many cases, they are ineligible for health care coverage, as well.* (Shapiro & Greenstein, 1988, p. 2)

In addition, the national trend toward a policy of least restrictive environments for treatment of mentally ill people resulted in a Texas policy of releasing as many patients as possible from state-funded mental hospitals so that they could seek community care. This decision did not necessarily result in significant shifts of state funds to community-based mental health care programs, and some former hospital patients have become homeless street people or semi-permanent shelter residents.

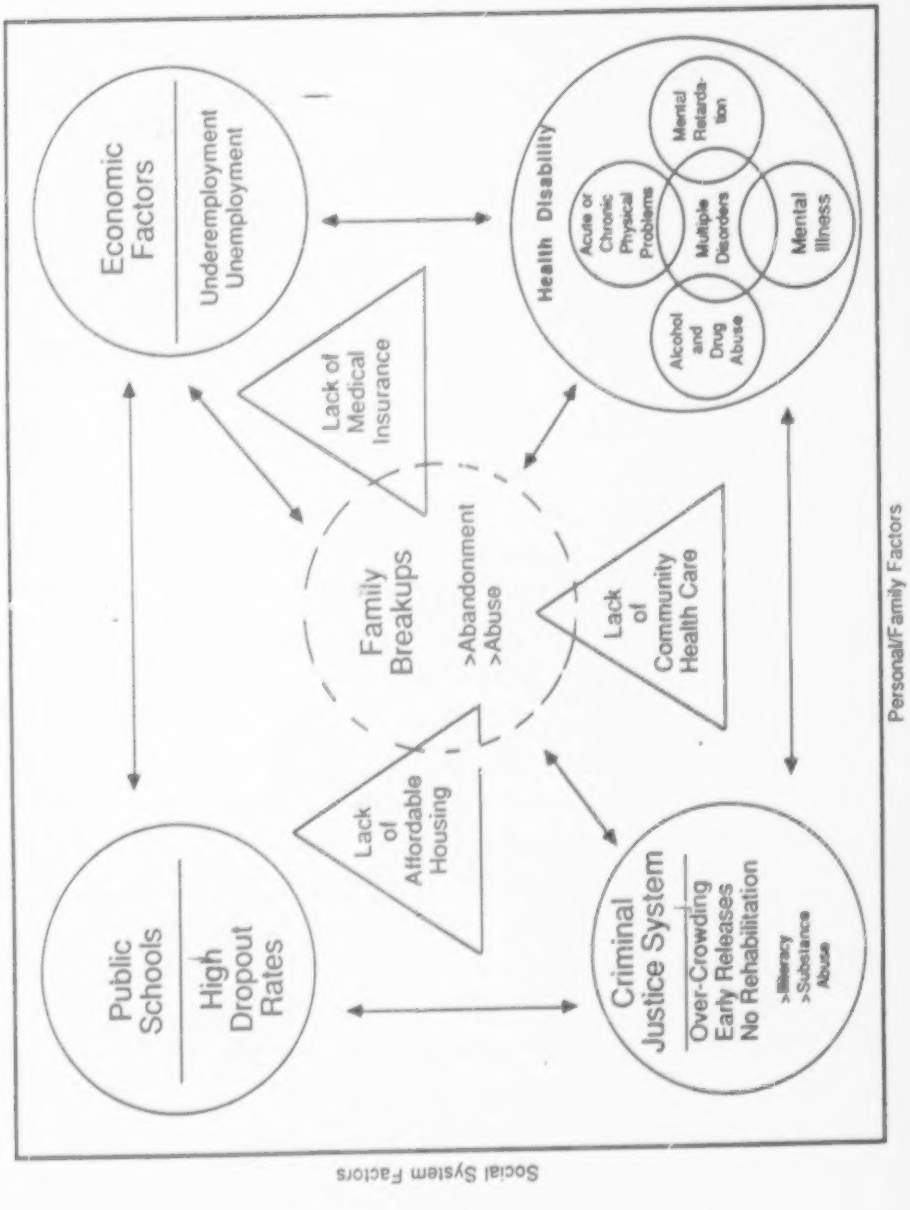
This socioeconomic context includes schools with high dropout rates, an economy in transition with dislocation of workers, growing numbers of criminal convictions and releases due to overcrowded penal facilities, restricted public assistance programs, and deinstitutionalization policies for state mental hospitals which release many patients. The complex relationships among these social system factors and personal/family factors generate a large and growing population of homeless people in Texas (a process which is illustrated in Figure 1).

B. RESEARCH FINDINGS ON HOMELESS PEOPLE IN TEXAS AND THEIR HEALTH CARE NEEDS

A review of the social sciences literature results in the identification of very few research studies focusing on the characteristics and needs of homeless people in Texas. Drawing on agency documents, including unpublished studies, committee findings and applications for grants helps to increase our understanding of homeless issues in this state. Due to the different assumptions and technical resources of these projects, however, conceptual and methodological problems often make comparisons difficult. Some of the major indicators are summarized below.

CHARACTERISTICS OF THE HOMELESS IN TEXAS - Findings from a needs assessment study on homelessness sponsored by the State Government (Texas Health and Human Services Coordinating Councils, 1985) suggest that homeless people are predominantly Texans, with some being recently unemployed individuals and parents with children who migrated from one Texas community to another in search of employment. Other homeless people are local residents who lost their housing due to commercial development, while some can no longer maintain their families due to the rising cost of living. The study concludes that factors contributing to homelessness in Texas include: 1) high unemployment and poverty; 2) deinstitutionalization of the mentally ill and insufficient community resources to care for them; 3) reduced availability of low-cost housing; 4) reductions in funding for federal assistance programs, combined with tightened

Figure 1
Sources of Homelessness Which Impact Low-Income Families in Texas


Public Schools
High Dropout Rates
Economic Factors
Underemployment
Unemployment
Lack of Affordable Housing
Lack of Medical Insurance
Family Breakups
>Abandonment
>Abuse
Lack of Community Health Care
Criminal Justice System
Over-Crowding
Early Releases
No Rehabilitation
>Illiteracy
>Substance Abuse
Health Disability
Acute or Chronic Physical Problems
Mental Retardation
Multiple Disorders
Alcohol and Drug Abuse
Mental Illness
Personal/Family Factors
Social System Factors

eligibility criteria; 5) a perceived economic boom during the early 1980s that drew unemployed individuals to the state; 6) illegal migration from Mexico; 7) a mild climate with relatively low unemployment rates in the past; 8) easy access to cross-county transportation routes; and 9) growing family problems resulting in marked increases in the number of abused and abandoned women, children and adolescents.

Social science research to determine the number of homeless people in Texas demonstrates national arguments about methodological problems and controversies. One major effort to define how many homeless people are in the state concludes that the large numbers of marginal or homeless individuals attracted to Texas in the early 1980s has either declined or moved on elsewhere in hopes of greater economic opportunities; nonetheless, by using a HUD estimate of 25 per 10,000 population, they conclude that "*the homeless remain a considerable presence in the state, numbering some 40,000 or more.*" From analyses of Salvation Army data in Austin, they also suggest that the majority are predominantly White/Anglo, unattached, young males, able and looking for employment (Baker & Snow, in press). Critiques of this conclusion note its reliance on Salvation Army data in only one city to determine demographic characteristics of homeless people and the fact that it did not study families at all. These data are not necessarily representative of other major cities which have a much wider range of shelters.

Another study of homeless people in Austin also challenges the perception that homeless people in Texas and other states include primarily mentally ill individuals. The authors discuss a number of factors which lead communities to stereotype the homeless as being mentally ill (unclear diagnostic definitions, medical research models which focus on pathology, the greater visibility of the homeless due to their appearance, researchers' lack of understanding about the function of what appears to be bizarre behavior), and they conclude that the typical homeless person is "*a psychiatrically non-impaired individual trapped in a cycle of low-paying, dead-end jobs which fail to provide the financial wherewithal to get off and stay off the streets*" (Snow et al., 1986, p.

421). Other findings document the complex roles and psychological pressures faced by homeless street people and their efforts to maintain self worth and dignity (Snow & Anderson, 1987).

While community-sponsored studies in Texas have not always had adequate resources to do carefully controlled research on homeless characteristics, the increased number and activities of local homeless coalitions and task forces document the growth in population and problems of homeless people in our state. For example, reports are available from task forces in Austin, Dallas, Fort Worth, and Houston, while other communities have less formal documentation, all attempting to determine how many people are in their communities, what the major services needs include and how cooperative efforts could make a difference. These information collection and analysis attempts in many cities led to applications for federal funding. Most of the findings suggest dramatic demographic changes, particularly in terms of growing numbers of women and two-parent families with children, and urgent need for coordinated efforts to address both emergency services and employment programs. Health issues generally focus on the lack of primary health care, the needs of deinstitutionalized mental patients and problems of substance abuse services.

BARRIERS TO SERVICES FOR HOMELESS PEOPLE IN TEXAS - A 1985 statewide needs assessment project identified four major categories of barriers to social services for homeless people in Texas: 1) access to services (especially lack of awareness among both the homeless and state workers); 2) coordination of services (the lack of a lead state agency and a commonly accepted definition of homelessness resulting in inadequate information for planning); 3) qualifications for services (complex eligibility procedures and problems faced by homeless people in attempting to document their circumstances); and 4) program funding (insufficient service capacity to meet the needs of the large number of homeless individuals and families). A major conclusion is that, "*There is no way local governments coupled with charitable organizations can fund all of the services needed by the homeless*" (Texas Health & Human Services Coordinating Council, 1985, p. iv).

Surveys of street people and shelter residents in Austin resulted in the identification of two types of barriers to services for the homeless (Baumann & Grigsby, 1988; Baumann et al., 1985; Baumann et al., 1988).

The first are psychological barriers among homeless people. Due to feelings of hopelessness and powerlessness, they tend to deny their health care problems, perceiving their poor health status as "normal" and thus are less likely to seek or use health care services. The second are structural barriers in the health care delivery system that make it difficult for homeless people to access and use it effectively. These include usability factors (rigid eligibility criteria, inability of programs to help due to limited resources, negative attitudes and behaviors of service providers), awareness (the lack of information among homeless people about community resources), and discordance in public policy decisions (the tendency of many communities to rely on local penal systems to manage public intoxication and other inappropriate behaviors).

The authors point out that psychological barriers can foster structural barriers, in that when homeless people don't seek out help, service providers will not have to adjust their programs to meet the needs of the homeless. Similarly, structural barriers can influence psychological barriers, with feelings of hopelessness being strengthened when services are denied due to eligibility requirements or other structural factors. The authors conclude that taking health care services to shelter residents and street people through the use of mobile vans is an example of a technique that will help to break both types of barriers and assist in reintegrating homeless people into the community service network.

The needs assessment effort on behalf of the homeless sponsored by the state of Texas concludes that efforts to coordinate planning and services would require an interagency task force or designation of a lead state agency. It also emphasizes the need to explore establishment of common residency and address requirements, the promotion of case management for the homeless and additional support for public/private partnerships to assist the homeless (Texas Health & Human Services Coordinating Council, 1985). A study of services to chronic mentally ill individuals discharged from Texas state and/or county mental hospitals documents the effectiveness of case management in linking clients with services but at a higher cost, and it did not find significant changes in their quality of life. The authors note, however, that the overall efficiency and effectiveness of case management may be tied to the availability of local resources, as well as the philosophy and operation of the community mental health center responsible for the clients (Franklin el al., 1987). Other research studies emphasize the need for state interagency communication and coordination to help develop uniform and comprehensive data collection efforts (Baker & Snow, in press). Local assessment efforts, such as those of the Houston Coalition for Health Care for the Homeless, suggest that initiatives such as intake mobile units located near shelters are not necessarily effective in increasing access.

In order to build on these somewhat limited findings from the research literature and policy arena, the Benedictine Center implemented three research efforts to learn more about the health care needs of homeless people throughout Texas: a census of emergency shelter residents, an opinion survey of key community decision makers, and a series of field site visits. Figure 2 shows the regional breakout of the state and which cities were included (see Appendix B for more information about the research design and process).

C. HOMELESS EMERGENCY SHELTER CENSUS

With the objective of gaining a better understanding of the types of people in Texas who use emergency shelters, the Center asked directors of 100 shelters throughout the state to take a census of the people in residence at their facility on one night; 81 shelters participated, and more than 3,100 residents were interviewed. The major finding was that homeless men and women have different needs, as do different racial/ethnic groups; therefore, most of the following results emphasize this group diversity. Figure 3 to 12 illustrate their variations. In addition, because geographical factors were sometimes important to understand the circumstances of homeless people and service providers attempting to assist them, most results are also compared across five regions of the state (see Tables 1-11 in Appendix C).

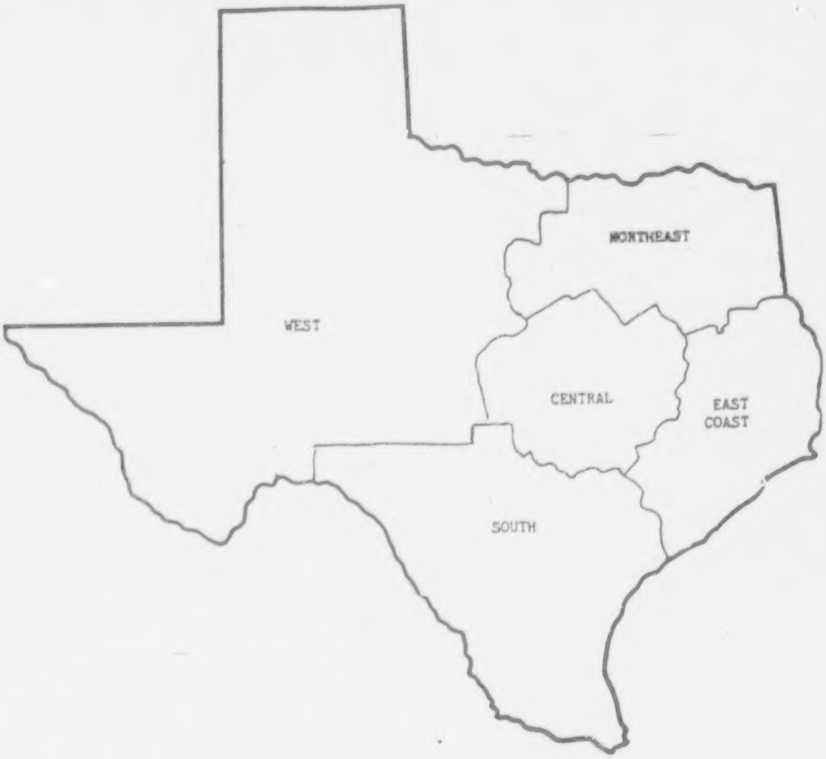
RACE/ETHNICITY - Homeless people residing in emergency shelters in Texas reflected the ethnic diversity of the state: 50% were White or Anglo, slightly more than 28% were Black, and 18% were Hispanic, with 3% Native American or American Indian and 1% Non-Hispanic Other.

GENDER - The great majority of the shelter residents were men, but more than one fourth of the residents were adult women.

Figure 2

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS CITIES INCLUDED IN SHELTER CENSUS AND SURVEY



EAST	NORTHEAST	CENTRAL	WEST	SOUTH
Baytown	Arlington	Austin	Abilene	Brownsville+
Beaumont	Cleburne*	Bryan	Amarillo	Corpus Christi
Conroe*	Dallas	Kerrville*	El Paso	Edinburg
Galveston+	Denton*	Marble Falls*	Lubbock	Harlingen
Houston	Ft. Worth	San Marcos*	Midland	Laredo+
Pasadena*	Longview	Waco+	Odessa	McAllen
Port Arthur+	Paris*		San Angelo	San Antonio
Texas City+	Sherman		Wichita Falls	Victoria+
	Temple+			
	Texarkana*			
	Tyler			

* - Cities included in the Shelter Count only.
+ - Cities included in the Survey only.
Other cities were included in both the Shelter Count and the Survey.

TEXAS SHELTER CENSUS OF HOMELESS PEOPLE - 1988

Selected Demographic Characteristics

Figure 3
Gender/Age Groups

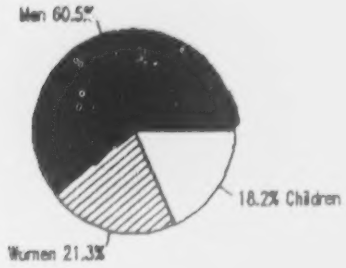


Figure 4
Race/Ethnicity (Adults)

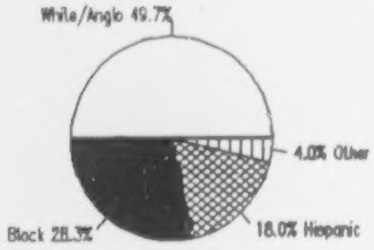


Figure 5
Adult Ages

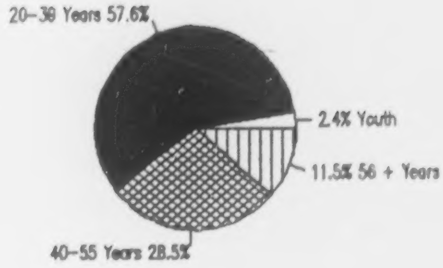
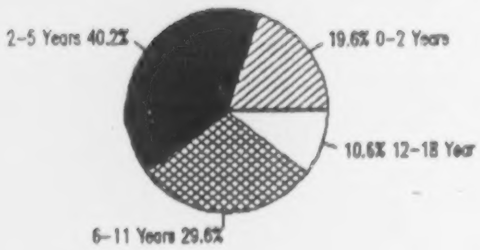


Figure 6
Children's Ages



Women in emergency shelters (68% of the total women) differed in several ways from women in family crisis or battered women's shelters (32% of the women). Women in emergency shelters were older and more likely to have first used a shelter at an earlier date. They had a higher unemployment rate and were less likely to perceive themselves as able to work. In contrast, women in family crisis centers were younger, tended to have more children, and were more likely to be Native Texans. About one-third were working at least part time, and over half perceived themselves as able to work.

ADULTS - The ages of residents ranged from 14 1/2 to 86 1/2 years, and the average age was 38.4 years. Almost 58% were between the ages of 20 to 39, with only 2.4% being 19 and under (i.e., they were unaccompanied minors residing in the shelters) and 2% being 66 or older. But racial/ethnic groups varied considerably, with White/Anglo males being the oldest group and Hispanic females the youngest, and women tended to be younger than men in all cases. All regions had a majority of young adult shelter residents, but South and West Texas tended to have more young residents than other areas, while Central and East Texas had more elderly residents.

CHILDREN AND YOUTH - There were only 19 unaccompanied minors aged 17 or younger in the shelters who were interviewed, but an additional 629 children and adolescents stayed in the shelters that night. They were not interviewed but were counted with the 407 adults who accompanied them, almost 70% of whom had one or two children with them. Sixty percent of the children were less than 6 years old, while another 30% were between the ages of 6 to 11.

VETERAN STATUS - About 31% of the entire group were veterans, the great majority of them being men. White/Anglo men had a larger percentage (52%), while one third of the Black men and 18% of Hispanic men were veterans.

EDUCATIONAL STATUS - More than 53% of the homeless shelter residents had completed high school, almost 22% had some college education, and 5% had finished college. But important racial/ethnic and gender differences existed. At least 50% of each subgroup had completed high school with the exception of Hispanics (only 22% of the men and 31% of the women had finished) and Native American men (42% completion).

TEXAS SHELTER CENSUS OF HOMELESS PEOPLE - 1988

Selected Demographic Characteristics

Figure 7
Age Distribution by Race/Ethnicity

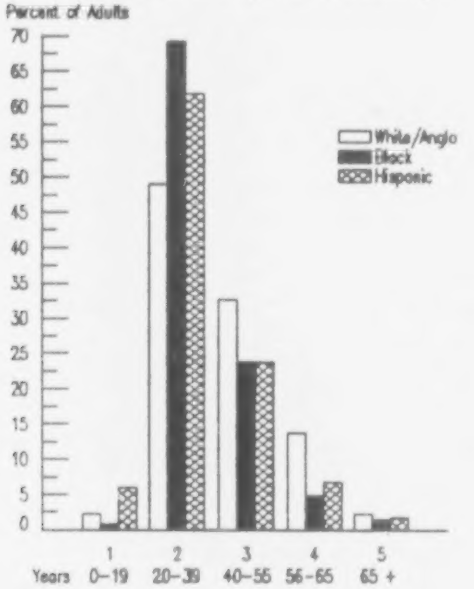


Figure 8
Time in Texas (Adults)

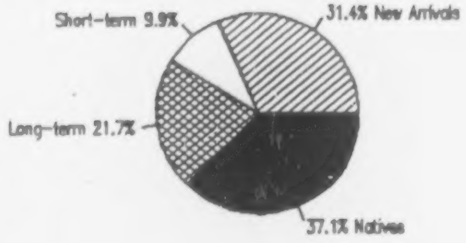
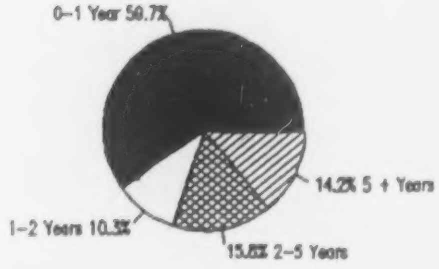


Figure 9
Time Since First Use of Shelter (Adults)



TEXAS SHELTER CENSUS OF HOMELESS PEOPLE - 1988

Selected Demographic Characteristics

Figure 10
Percent of Veterans by Race/Ethnicity

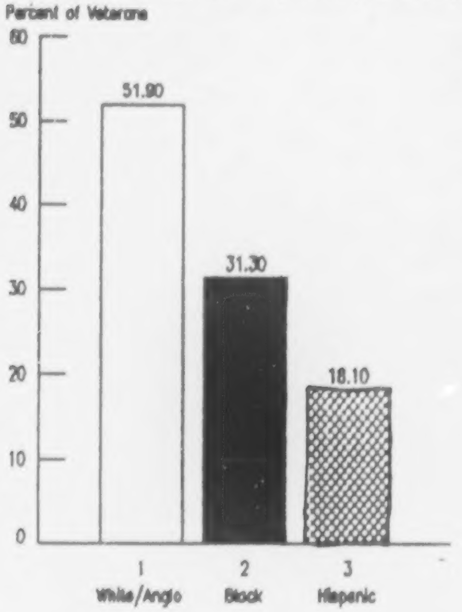


Figure 11
High School Graduates by Race/Ethnicity

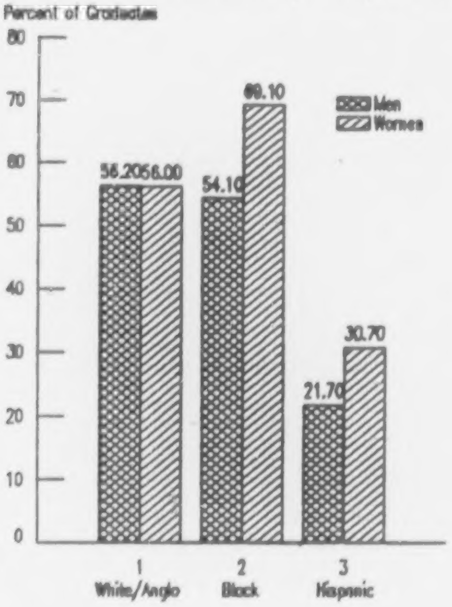
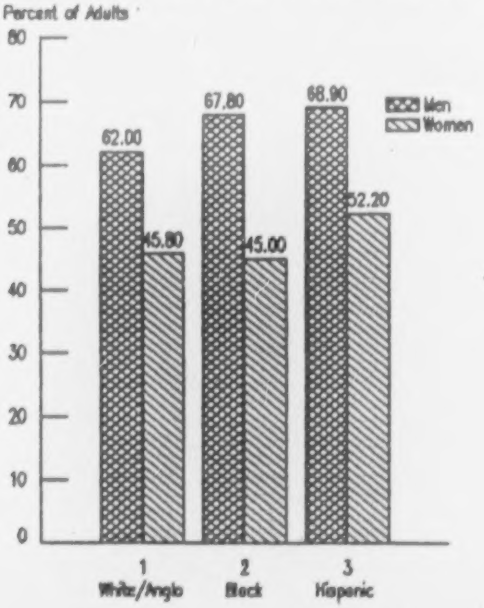


Figure 12
Perceive Themselves as Able to Work



TIME IN TEXAS - More than 37% of the homeless shelter residents had spent almost their entire lives in Texas and can be classified as Native Texans. At least one third of all respondents in each region were Native Texans, while Central and South Texas had larger percentages than other areas, and Northeast and West Texas had the lowest rates. Blacks and Hispanics tended to be Native Texans at a higher rate than Whites/Anglos, and women were more likely to be Native Texans than men.

Of those homeless people who were not natives, the average number of years that they had resided in Texas was 8.4 years, varying across racial/ethnic groups from 5 to almost 9 years. Whites/Anglos had been here slightly longer than other groups, and Hispanic males had the lowest rates (an average of 6.8 years) of the major subgroups. One regional comparison showed that less than one third could be perceived as "recent arrivals" (having lived in Texas for 12 months or less), and, thus, few should be perceived as short-term transients. The exception was West Texas, which had less than 50% Native Texans or long-terms residents and almost 45% recent arrivals. East Texas, the Houston area, had the longest average residence time.

DURATION OF HOMELESSNESS - One indicator of how long the residents had been homeless was the length of time since they had first used an emergency shelter. The vast majority of these Texas homeless people seemed to be new shelter users: 60% of the respondents had first used a shelter within the last 12 months and 28% within the last month. One to two years had passed for 10% of them, while only 30% had first used a shelter more than two years ago.

EMPLOYMENT - As would be expected, at least two thirds of the homeless respondents were unemployed. Nevertheless, from 29% to 33% reported themselves as full-time or part-time employed or as day laborers -- yet they were residing in an emergency shelter. Nearly two thirds of the men and almost half of the women reported themselves as being "able to work."

BARRIERS TO EMPLOYMENT - Each respondent was asked to identify anything that might keep them from being able to work. The responses of the 845 people who mentioned at least one problem were then grouped into broad categories (see Figure 13 for an overview of their responses):

Figure 13

TEXAS SHELTER COUNT OF HOMELESS PEOPLE - 1988

Reported Barriers to Employment by Race/Ethnicity and Gender [a]

	Health				Personal Resources				Structural Barriers			
	Physical	Pregncy	Mental	SubAbuse	Educatn	Age	ID/Doc	No Home	NoJobs	DayCare	Transprt	Discrim
Men												
White	1st		*			*			2nd		3rd	
Black	1st		3rd		*				2nd		*	
Hispanic	1st		*				3rd		2nd		*	
Women												
White	1st	3rd	*		*				*	2nd		
Black	1st	*	2nd		*				*	3rd		
Hispanic	3rd	*			2nd		*			1st	2nd	

[a] About 30% of the respondents answered the open-ended question, "Is there anything that stops you from being able to work right now?"

1st, 2nd & 3rd = the three factors most frequently identified by members of each subgroup as a barrier.

* = factor identified by 5% or more of the subgroup as a barrier.

See Table 8 in Appendix C.

- * The Major Barrier: Physical Health - Every racial/ethnic-by-gender group identified physical health factors as a barrier to employment (including 50% of the White/Anglo and Black males, 30% of White/Anglo women and Hispanic men, and 28% of Black women).
- * Other Barriers for Men - All three racial/ethnic groups of men dentified the poor economy and lack of jobs as their second major factor, including 27% of Hispanic men.
- * Other Barriers for Women - All three racial/ethnic groups of women identified the lack of child care and care for sick dependents as a major barrier to employment. More than 35% of Hispanic women mentioned this factor, making it the barrier most often identified by their group, while it was the second major barrier for White/Anglo women (20%) and the third for Black women (18%). Almost 10% of all three groups mentioned pregnancy, and it was the third most often identified barrier by White/Anglo women. About 15% of Hispanic women mentioned their lack of education as a barrier to employment, making it their third most frequently identified, and nearly 13% of Black women mentioned lack of education.
- * Mental Illness as a Barrier - Blacks tended to identify this factor much more often than other groups. It was the second most often identified by Black women (17%) and the third by Black men-(16%).
- * Substance Abuse as a Barrier - Barely 2% of any group, with the exception of Hispanic men (5%), identified this factor.
- * Transportation - Nearly 17% of Hispanic women mentioned transportation, making it the second most frequently identified barrier for their group, and 11% of White/Anglo men mentioned it, making it the third most often identified by them (over 9% of the White/Anglo women also mentioned this factor).

- Lack of Identification or Documentation - Only Hispanics identified this factor as a barrier to employment in any large numbers,including more than 15% of Hispanic men, thus making it the third most often mentioned factor for their group, and 9% of Hispanic women.

Very few emergency shelter residents who participated in the interviews admitted to any use of alcohol and drugs and/or problems with mental illness. It may be that these persons are not admitted to shelters as often due to their disruptive behavior; or they are quite reluctant to admit to these problems in a casual circumstance. Probably, both explanations are correct.

D. SURVEY OF KEY DECISION-MAKERS ABOUT COMMUNITY SERVICES TO HOMELESS PEOPLE IN TEXAS

In order to learn more about what local service providers and policy leaders see as the major problems of homeless people at the community level, the Center surveyed the opinions of 584 key decision-maker in 31 cities across Texas. The categories of the respondents included: (1) homeless advocates and direct service providers to homeless people; (2) health and human service administrators; and (3) community leaders. A total of 301 individuals, or 51.5%, responded. Fewer community leaders responded than did service providers and administrators, but there was even geographical representation (see Tables 12-22 in Appendix D).

PERCEIVED CURRENT CHARACTERISTICS OF HOMELESS PEOPLE IN TEXAS - The respondents outlined their perceptions of the following factors:

- Age and gender - Almost all respondents reported that the largest group of homeless individuals in their communities were young adult males (age 20 to 40). Direct service providers and homeless advocates were the only group which was more likely to identify adult women with children as the largest group. Administrators and community leaders tended to identify older adult men more frequently.

Regional differences included a tendency to report more female heads of households in Central, West and South Texas. South Texas respondents also differed in their reporting of higher proportions of older men, the elderly and teenage mothers.

- * Race/Ethnicity - The three groups all categorized the majority of the homeless in their community as being White/Anglo, with less than half as many respondents identifying Hispanics and even fewer reporting Blacks or other groups.

  Not surprisingly, given the demographic factors in Texas, there were very strong regional differences on this issue, with much higher reporting of Hispanics in the South, a considerable rate in West Texas and relatively negligible figures in other regions. Respondents in East Texas identified Blacks at a much higher rate.
- * Education - Service providers tended to report higher levels of education among the homeless. Administrators were the most likely to be uncertain about this issue. South and West Texas respondents reported lower levels of education more frequently.
- * Health Status & Work Ability - Service providers were much more likely than other groups to perceive homeless people in their community as being "able to work." Administrators tended to categorize the local homeless as unable to work due to mental illness and alcohol/drug abuse. There were no major regional differences; all respondents identified the physically able and those unable to work due to mental illness most frequently.

PERCEPTIONS OF RECENT CHANGES IN THE CHARACTERISTICS OF LOCAL HOMELESS PEOPLE - All three categories of respondents reported strong indications of changes in the demographic characteristics of homeless people in their communities. They generally described these changes as:

- * Increased numbers of female heads of households and two-parent families;
- * Increased numbers of Whites/Anglos and of Hispanics;

- Increased numbers of homeless people with higher education levels, e.g., some high school education or high school graduates; and
- Increased numbers of homeless people able to work but also of those unable to work due to mental illness.

PERCEPTIONS OF MAJOR HEALTH CARE PROBLEMS OF HOMELESS PEOPLE - More than 82% of the respondents identified alcohol and drug abuse, while more than two thirds also identified dental problems, 62% severe mental illness and 54% infections. One interesting finding is that one third of the respondents identified sexually transmitted diseases and 23% reproductive/genito-urinary disease, health problems less often mentioned in the literature.

What Are the Most Important Unmet Needs of the Homeless? - Survey respondents overall ranked affordable housing, employment, and emergency shelter as the most important unmet needs of the homeless. Other issues identified included job training, medical care, food and nutrition, and mental health care. Although all three groups agreed by ranking housing and employment as the most important unmet needs of homeless people in their communities, there are interesting differences among the categories of respondents. Homeless advocates and direct service providers ranked affordable housing higher, while administrators rated employment lower than the other two groups. The pattern of community leaders differed somewhat from that of the other two groups. For example, leaders ranked job training, food/nutrition and literacy/education services higher. Administrators tended to rate medical care and transportation somewhat higher, while advocates and service providers ranked child care considerably higher than other groups.

The results also document regional variations of emphasis. All regions identified affordable housing as the most important unmet need, except for South Texas which ranked it second, with employment being first. West Texas rated job training much higher than other regions. East Texas ranked medical care lower but ranked mental health care higher, while West and South Texas rated alcohol and drug abuse services lower than other regions.

Which Health Care Services Are Needed Most by Homeless People? - Statewide decision-maker suggested that in terms of health problems, homeless people in Texas need: outreach programs to help them access existing services, special mental health services; ambulatory or walk-in clinics in appropriate areas; and special alcohol/ drug abuse services.

The categories of respondents differ, however, in their ranking of the most needed homeless health care services. Advocates and shelter directors ranked walk-in clinics as the most needed, while administrators and community leaders picked outreach programs. All three groups emphasized special mental health services. Administrators and leaders ranked special alcohol and drug abuse services higher than advocates and service providers, while the latter rated mobile health care units much higher than the other two groups.

Regional differences also reflect different perspectives, with Northeast, Central and South Texas ranking outreach programs as the most needed, while Northeast picked special mental health services and West Texas emphasized walk-in clinics. Most regions ranked special alcohol and drug abuse services as either their third or fourth choice.

Who Should Pay for Homeless Health Care Services? - The public sector received the highest ranking, with the federal and the State governments being identified most often. County and city governments were also frequently identified.

Advocates and service providers essentially agreed with community leaders that the federal government has the major responsibility to pay for homeless health services, with support from the State of Texas and county and city governments. Administrators showed a similar pattern but responded that the State Government has the primary responsibility. Advocates and providers emphasized the role of religious and private charities more than the other two groups did, while administrators did the same with the United Way, i.e., local community-supported agencies.

The regional variations demonstrate a similar pattern of identifying the public sector as having the major responsibility of paying for homeless health care services. East, Central and South Texas ranked the federal government first, while Northeast and West Texas emphasized the State Government's role. Northeast Texas also differed with a much lower ranking of city government and a greater emphasis on the responsibility of private health care providers. See Figure 14 for a summary of perceived homeless service needs.

E. SITE VISITS TO MAJOR URBAN AREAS IN TEXAS

To understand some of the local circumstances related to findings from the emergency shelter census and the survey of community decision-makers, Benedictine Center project staff made a series of site visits to 11 Texas cities in the Spring of 1988; 193 individuals involved with services to the homeless and other indigent people, health care, and community leadership were interviewed (see Appendix E for a list of people who were contacted). The major findings of this process are summarized below.

BARRIERS TO HEALTH CARE AND SOCIAL SERVICES - Four different types of issues were identified as creating barriers to homeless people's use of health care and social services. The first relates to the organizational philosophy and administrative policies of organizations, the second to the availability of services, the third to situational issues, and the last to perceptions by service providers of characteristics of homeless people and how they are affected by the first three types of issues.

(1) Organizational Philosophy and Staff Characteristics - Some large homeless service agencies have long histories and extensive programs. Most emergency shelters and other assistance programs for homeless or low-income people are sponsored by religious institutions or groups, and many are operated by one administrator and a limited number of staff, along with several church or religiously affiliated volunteers. They are often assisted by homeless people who have made some kind of commitment to the program and who have both special privileges and responsibilities in contrast to other residents. The individuals who make decisions and who run the programs are often highly motivated, with strong principles regarding charitable work and the need for rehabilitation of the less fortunate. They do not always have extensive training in management or social services, and most prefer not to involve themselves in collaborative relations with government-sponsored programs so as to preserve their religious focus and independence.

Figure 14

TEXAS COMMUNITY OPINION SURVEY ABOUT SERVICES FOR HOMELESS PEOPLE

Decision-makers' Ranking of Priority Services For Homeless People in Texas*

Most Important Needs to Meet the Long-range Well Being of Homeless People in Their Communities

1. Affordable Housing
2. Employment
3. Emergency Shelter
4. Job Training

Most Needed Homeless Health Care Services

1. Special Mental Health Services
2. Ambulatory Clinics in Accessible Locations
3. Special Alcohol and Drug Abuse Services
4. Mobile Health Care Units

Which Groups or Agencies Should Have Major Responsibility to Pay for Homeless Health Care Services

1. Federal Government
2. State Government
3. County Government
4. City Government

* See Tables 17-22 in Appendix D

Many of the volunteers and staff members are uncomfortable with community public health services, which may require a provider to suspend value judgments of an individual's behavior in order to provide treatment or attempt to encourage a change. Shelter workers and church group members involved in homeless advocacy and service also reflect a sociocultural uniformity, in that the vast majority are White/Anglo, monolingual English-speakers from a middle-class background. They may not be aware of how their assumptions can generate discomfort in a racially or culturally different homeless person. For example, when questioned about the functioning of Spanish-speakers, the administrator of one rehabilitation program responded, "They're expected to speak English here." Horror stories about experiences in hospital emergency rooms abound, such as one instance where the janitor had to translate for the nurse on duty so that a homeless woman who had been assaulted could be diagnosed and treated.

Operationally, most shelters are set up to provide a safe, minimally comfortable place to sleep, along with an evening meal, a breakfast and perhaps a sack lunch, seven days a week. Few of them permit residents to remain inside during the day, and most do not provide any kind of structured daytime services. The objective is that residents should be out looking for work, yet assistance, referral and training programs to help are few. More comprehensive programs often have very intensive, demanding schedules with a focus on individual development, which makes it difficult for a homeless person with family responsibilities (such as a woman with children) to participate.

In contrast, most social service agencies operate Monday through Friday, from 8:00 to 5:00, frequently requiring an appointment in order to obtain assistance. Several community respondents described what they perceived as inappropriate waiting periods and complex procedures to become certified as eligible for public assistance. In one city, an elderly man was late for his food stamp appointment because he had to walk across town to the local human services office. The worker there told him that he would have to return and that the next available appointment would be in three weeks. The man left without protest, though in great despair, because his wife was physically handicapped, and he hated leaving her at home alone. Ironically, the director of the local food bank learned of the elderly couple's plight when she discovered the old man going through her garbage that night, trying to find something to feed his wife.

Shelter directors in several cities expressed concern about the limitations of their facilities, staff and volunteers in dealing with seriously ill homeless people and providing respite care. They described "inappropriate releases," or what they perceived as a growing tendency on the part of hospitals to release homeless people after major surgery or other treatment and to direct them toward the shelters. The administrators also feared that the shelters will increasingly become hospices for older homeless people or others with lingering illnesses and terminal diseases.

(2) Availability of Services - In case of life-threatening emergencies, most homeless people in urban areas can obtain health care, usually in the emergency room of the county hospital. Some needed health care services which could make significant differences in the general health and employability of homeless people, however, are often not available (for example, dental care and vision corrections). Smaller cities and rural communities which do not have hospitals are generally unable to provide emergency indigent care and instead wrestle with issues of responsibility and transportation logistics. The lack of public treatment facilities for indigent substance abusers and of services for the chronically mentally ill are discussed in more detail later because of their importance.

(3) Situational Factors - The circumstances of living on the street or in an emergency shelter when indigent often make it difficult for a homeless person to behave according to the expectations of service deliverers. Because they are regularly assaulted and robbed, they seldom have all of their identification documents, a watch or a change of clothes. For the same reason, they often are fearful and suspicious. Homeless individuals find it difficult to gain access to a telephone. Few have cars, and most cannot afford bus fares. Even when bus tokens are provided, the bus schedules in many Texas cities make it difficult for homeless people to visit agencies and to keep appointments. Homeless women face additional problems in trying to arrange for child care or in taking their children

with them. Homeless people's general lack of access to bathrooms results in unpleasant personal characteristics that influence the reaction of other people to them and probably generate other negative perceptions.

(4) Perceptions of the Characteristics of Homeless People - Several social workers mentioned how staff members in public assistance agencies were having a hard time dealing with the "new homeless." These individuals had never had to request federal or state benefits before, and they are perceived as behaving inappropriately. The new clients are angry and upset about what they view as questions invading their privacy and shaming them even more about their unemployment and the loss of their home; and, as former taxpayers who always assumed that a "safety net" existed for people in need, they resent the long waits, delays and uncertainties in determining their eligibility for benefits. In contrast, homeless people who have been on the street for a long time are often viewed by service providers as unmotivated, irresponsible, essentially criminal and full of hopelessness and defeatist attitudes. For example, one social worker expressed strong opposition to the distribution of food stamps to homeless people, "because they use them to buy alcohol and sex." The general lack of education and literacy among many homeless people makes it difficult for them to comply with detailed instructions to document their circumstances. In both cases, a homeless client is often defensive and may assume either a hostile or a passive manner when requesting assistance; the negative attitudes of some social service providers makes it difficult to develop respectful and potentially helpful relationships.

THE ROLE OF LOCAL HOMELESS ADVOCACY GROUPS - Many Texas cities originally formed coalitions to help homeless people in response the opportunities offered for foundation funding. Although all did not receive grants, the coalitions continued, and several communities succeeded in raising local funds to develop assistance programs. These advocacy groups also serve to stimulate and maintain local awareness of the needs of the homeless and to foster information collection to assist with long-range planning. Where such coalitions have not been formed, services to homeless people are less well coordinated, and many service providers and community leaders seem much less informed about the needs of the homeless.

One current problem facing several local coalitions is focusing on the next steps of organizational development. Many were successful in creating and maintaining emergency shelter and food services. One major source of support was often downtown business people who were eager to improve the image of their commercial areas. Coalition members now face much more difficult tasks of determining how to reintegrate homeless people into the community. Attempts to determine priorities in terms of literacy services, job training programs and employment referral efforts absorb the attention of most groups; because many coalition members are volunteers or people somewhat unfamiliar with homeless rehabilitation efforts, they are struggling to determine what kinds of projects could make an effective difference. The need of many homeless people for extensive and comprehensive assistance and the finite resources in communities challenge coalitions to develop innovative responses, but the advocacy groups require technical assistance and information about successful models to help their planning process.

HEALTH DATA FROM A SHELTER-BASED CLINIC PROJECT - Service statistics from a homeless health care project in San Antonio provide suggestions about the types of illnesses and diseases encountered by homeless people in that community (the service delivery model is described in more detail in Chapter V). However, it may be that the data are not necessarily representative of Texas as a whole. From its initiation in 1985 through April 1988, the project has seen almost 4,000 patients, with an average of 3.5 visits per patient. The program is unusual, in that 42% of the patients were Mexican American or Hispanic and 10% Black, a pattern representative of San Antonio but not found in other sites. About 33% of the patients were female. Almost one forth of the patients were children or adolescents 19 years old or younger. Nearly 53% of the adults had completed high school or a higher level of education. About 26% had received some type of social service entitlements. Over 80% of the contacts were client initiated.

The nurse practitioners served as the primary provider for nearly 53% of the patients, while it was a social worker for 24% of the patients. In terms of medical histories, the most frequently reported disorder was alcohol abuse. Other medical conditions and procedures, respiratory diseases, nervous systems and sense organ diseases, and injuries and poisonings accounted for about 57% of the medical problems presented. Although the highest proportion of visits were for medical problems, the highest referral rates were for drug abuse and mental illness. However, more than 65% of the clients presenting with alcohol problems and 44% with drug problems were not referred. Almost 32% of the problems presented to the health care team were actually social service related (assistance with eligibility for benefits, housing, employment, etc.) rather than medical problems.

CHEMICAL ADDICTION AND THE LACK OF PUBLIC TREATMENT FACILITIES - Many individuals interviewed throughout the state identified growing problems of alcoholism and different forms of drug abuse. Of particular concern were the younger age of many substance abusers and the violent behavior generated by use of crack. Numerous people commented on how much more dangerous street life had become in the last few years. Almost invariably, service providers admitted that they could seldom help homeless or other indigent people due to the lack of public treatment and rehabilitation programs; several cities lack detoxification facilities. An almost insurmountable problem for the homeless person fortunate enough to obtain detox and treatment services is the lack of alcohol-free residential programs which would support sober living.

THE NEED FOR CASE MANAGEMENT AND SHELTERED HOUSING FOR THE MENTALLY ILL - Most communities appear to be struggling unsuccessfully to serve these individuals, particularly the severely ill and many older women former patients. For example, one homeless mental health advocate insisted that the local community mental health center was overloaded and unable to respond to the needs of existing or new clients due to structural blocks to services, such as the failure of the State mental health agency to provide adequate funds for community services and the legal problems resulting from client's right to refuse treatment. The homeless advocate reported that one reason homeless shelters are crowded is that state hospitals continue to discharge clients too soon and without adequate coordination with local continuity of care caseworkers. There are long waiting lines for community services, with closed intake processes at some sites. The lack of supervision of boarding houses where many discharged patients end up and the failure to monitor community mental health centers by the State mental health agency ensures that more serious problems will continue, including life-threatening incidents.

Community mental health center staff reported that insufficient State funds were allocated to their agencies to increase staff to serve the influx of new patients discharged from State hospitals. Mental health advocates often countered that the centers do not emphasize case management sufficiently to maximize effective use of existing community resources and that community mental health centers should take a much more assertive role in fostering partnerships with other agencies and the private sector to develop a variety of housing programs for the mentally ill. There continues to be resistance in many neighborhoods to the creation of housing for the mentally ill. Without sensitive yet assertive advocacy and effective community leadership, progress on this issue will be difficult.

REGIONAL ISSUES - Several county officials expressed concern about local taxpayers' resentment toward the new Texas law requiring that up to 10% of county funds be designated for indigent health care in those counties which don't have public hospitals or hospital districts (County Indigent Health Care Program, or CIHCP). The officials also suggested that such amounts were insufficient to meet local health care needs, and they feared a resulting drain on county resources. Yet program reports from the Texas Department of Human Services (TDHS) document that nine months into Fiscal Year 1988, less than one third of the CIHCP counties had spent 40% or more of their allocated general revenue levies for indigent health care. Only seven counties, concentrated in Northeast and South Texas, had exceeded their limit. TDHS administrators suggested that such over-expenditures probably result from county programs which are responsive to the needs of local people. Thus, many Texas counties could make much greater efforts to use local resources for indigent health care services.

Service providers in West Texas believed that they served more transients than local homeless people, probably because of the geographical isolation of their major cities and the ease of access to interstate highways. Perceptions around the state tended to identify the Houston region as having the most serious homeless problems, and it does have more shelters and inexpensive boarding houses than most other metropolitan areas. Given the high incidence of homelessness and of AIDS in Houston, it is somewhat surprising that service providers there do not appear to have identified the multiple risks that AIDS represents to homeless people.

All metropolitan areas face serious chemical addiction problems which affect indigent people in a particularly devastating way due to the lack of public treatment and rehabilitation programs. Homeless service providers in Houston and Dallas reported their concern about drug abuse problems and the growing numbers of young unemployed, homeless Black and Hispanic men who express profound hopelessness and despair.

It is striking that South Texas appears to have no major emergency shelters for the homeless, other than a few in San Antonio and Corpus Christi. According to several people interviewed, families and friends attempt to assist people who have no place to go. One service provider told of referring homeless women and children regularly to the local jail, as it was the only safe public facility where such families could spend the night. Local leaders and service providers in rural areas worry about their communities' ability to provide services to homeless and other low-income people. As one elected official pointed out, Texas counties vary profoundly in their resources and in the perspectives and concerns of their leaders. This results in inconsistent quality of services and benefits; what is needed, in his opinion, is a state-funded indigent health care program which would provide uniform administration and fair assistance to all. The result would be less immigration to the cities by rural families:

> *Homeless people are human beings who shouldn't be driven from pillar to post. It's not right that a person who's forced to admit that he hasn't got any resources should have to go to four or five places trying to prove over and over again that he's poor and needy. Surely, we can come up with a better system.*

Or as another individual suggested:

> *Our Texas welfare system is crazy; it's a deficit, negative model, one that's always concerned about being ripped off and that never focuses on our people that desperately need help.*

> *I'm not nearly so worried about the 2-3% who might try to take advantage of the system, as I am about the 97-98% of our clients who truly need help. If we could provide fast and adequate assistance to a lot of these families, we could make a difference in their lives. As it is, we give very little and spend most of our energy on being absolutely sure that nobody gets a cent they're not entitled to.*

Caseworkers burn out from facing people's pain and anger every day and from the administrative documentation requirements in the face of that pain.

THE LINK BETWEEN HEALTH CARE AND OPPORTUNITY - The chief executive officer of one of the larger hospital districts in Texas stressed the importance of community-oriented primary care clinics because they can provide early medical care and will thus decrease the severity and the overall cost of illness, not just to the patient but also to the hospital district, taxpayers and society. The public hospital director concluded that preventive health care can also make a significant difference in the destructive social dynamics characteristic of many urban neighborhoods, and he challenged local communities to attack the most prevalent diseases of our inner cities so that they will not dominate our state's future: those illnesses which are *"self induced and fueled by low self esteem, hopelessness, and helplessness."* But he also emphasized the importance of education, fair housing, job availability and economic opportunity:

> *Opportunities have to be there before people quit sticking needles in their arms and quit having babies at age 13 so they can have something that belongs to them.* (Anderson, 1988, p. 6)

F. SUMMARY OF TEXAS HOMELESS HEALTH CARE RESEARCH PROJECT FINDINGS

(a) CENSUS OF RESIDENTS IN EMERGENCY SHELTERS - Perhaps the major point is that the majority of people staying in shelters are either Native Texans or long-time Texas residents. Despite the stereotype of some observers, outsiders or transients who are only passing through do not comprise most of the needy people in our communities. In addition, Texas has many new and diverse groups of homeless people which now include all racial/ethnic groups and numerous women with children. This appears to be the result of both family breakups and economic dislocation: many of the men seem to have resources (veterans' status, a high school education, perceptions that they are able to work), yet they are unable to find employment. Indicators of mental illness and substance abuse did not emerge in the findings; this may result from respondents' denial or the fact that many "difficult" individuals are not welcomed at emergency shelters due to the problems they create for staff and other residents. This is an important point, because people who don't stay in shelters possibly have different characteristics and more complex types of problems.

(b) COMMUNITY OPINION SURVEY - There are different perceptions of those who work directly with homeless people and those who are in positions to make decisions about new services and resources. Some administrators and community leaders seem to lack awareness about growing numbers of women with children, adolescents and two-parent families among the homeless in Texas; the relatively high levels of education of many homeless people; and the belief of direct service providers and homeless individuals about their ability to work (if only jobs were available). All three categories of decision-makers ranked outreach programs and special mental health services as major priorities for community homeless health care services, although they also targeted walk-in clinics and alcohol/drug abuse services. There seemed to be consensus that the public sector should pay for homeless health care services, primarily the federal and State governments.

(c) SITE VISITS - Several direct service providers expressed great consternation about the potential for continuing increases in the number of homeless people in their communities. When questioned about the extent of homelessness in his community and the capacity of his shelter to respond, one emergency shelter director just laughed. He questioned in turn, *"What do you mean by capacity? The Fire Department states that we have a capacity for 68-96 individuals. Our actual bed space is 102. Last night we sheltered 135 people."* Service providers believe that most of their local human service programs are stretched to the limit, particularly those of mental health and substance abuse. Quite a few decision-makers seem to be unaware of the growing number of young homeless Black men and marginally housed Hispanics, and very few minority spokespeople are visible among homeless advocacy groups and coalitions. Numerous shelter directors and homeless advocates demonstrated a clear understanding that the dropout rates of public schools and the growing number of criminal arrests when matched with a corrections system that provides little or no rehabilitative services (literacy, substance abuse treatment and prevention) will generate many more unemployable and ultimately homeless people. While they provide crisis intervention services, they emphasize the need for prevention efforts to keep families from losing their homes and to help young people to prepare for future employment.

C. AN OVERVIEW OF THE HEALTH CARE NEEDS OF HOMELESS PEOPLE IN TEXAS

Homeless people in Texas appear to suffer from the same pattern of acute and chronic health problems as outlined in the research literature. Lack of clinical data makes it difficult to project rates, but alcoholism, substance abuse, especially the growing use of crack and inhalants, and severe mental illness are generally identified as the major problems among homeless people. The growing number of homeless women and children underscores the importance of primary health care and other preventive services.

(1) ALCOHOL AND DRUG ABUSE SERVICES - The biggest gap in service appears to be the general non-availability of detoxification, treatment and rehabilitation services for indigent alcoholics and other substance abusers. Where limited facilities do exist, extraordinarily long waiting lists make a mockery of any referral process. It is unrealistic to plan for job training and employment services until the problems of chemical addiction are addressed; by not providing treatment programs, society stereotypes and condemns these abusers as unworthy of rehabilitation.

(2) MENTAL HEALTH SERVICES - Many urban areas need a variety of housing for mentally ill people: 24-hour supervised care for those incapable of living independently, transitional housing with staff assistance to help people assume more responsibility for themselves, and group housing to provide a supportive environment for individuals on their own. Another major factor is that legal solutions (i.e., the defense of mental patients' right to refuse treatment, medication, housing referrals and

whatever support services the system can provide) has in many instances led to the abandonment of the mentally ill, as community service providers despair of gaining the patients' cooperation in stabilizing their lifestyle. Consistently, most communities identify a need for local housing, accompanied by active case workers who can serve as advocates for the severely mentally ill.

(3) PRIMARY HEALTH CARE - The overload of county hospital and hospital district emergency rooms consistently described in all communities indicates the need of homeless people for health care services, particularly preventive care and minor primary care to avoid complicated, expensive emergencies. As discussed in Chapter IV, several Texas cities have demonstrated the feasibility of providing effective primary health care to homeless people in an efficient and responsive manner. Use of shelter-based clinics and the nurse-practitioner delivery model will attract and assist the homeless. The most noticeable gaps in service continue to be the provision of on-site treatment (including prescribed medications, glasses, dentures, etc.).

(4) PREVENTIVE HEALTH CARE - Poor dental health is a major health care need; attention to preventive services, including provisions of supplies and instruction on use, could make a difference for many of the children and younger adults. There is also a clear need for reproductive education and contraceptive services, especially for women, who are at constant high risk of sexual assault and abuse. In addition, homeless people are at high risk of AIDS, both in terms of sexual practices and intravenous drug use. Education and distribution of supplies could make a difference.

(5) SUPPORT SERVICES - In general, most (but not all) cities have developed sufficient emergency shelters and food programs to provide basic meals and overnight lodging for homeless people. Major gaps remain, however, in addressing what many homeless people view as their most important need: employment. Because of their limited education and skills, some homeless individuals need literacy and job training services. Others have sufficient education but have not been able to adapt to a tight job market and need help in making connection with potential employers and/or retraining programs to make them more employable. In all

instances, assistance with transitional housing, child care and transportation will usually be required before they can assume full financial responsibility for themselves and their families.

(6) SPECIAL POPULATIONS - There are identifiable groups among the homeless in Texas who have special characteristics or circumstances worth noting.

(a) Veterans make up a significant proportion among homeless men. It is unclear as to whether existing federal programs are not addressing their special needs, particularly in terms of mental illness and substance abuse and job training/referral services due to lack of resources, or whether new programs are needed.

(b) Homeless women clearly have different barriers blocking them from achieving more stable situations: pregnancy, child care, transportation and education. Without such support services, it will be difficult for them to provide for themselves and their children, thus suggesting that they are at very high risk of becoming permanently dependent on some form of public assistance.

(c) Ex-offenders are perceived by many community service providers as being a continuously increasing source of homeless people in Texas. Given that they are almost always illiterate, poor, unemployable, socially hostile and moderate-to-serious substance abusers, their needs overwhelm the limited resources available in shelters and those of local programs targeting homeless people.

(d) Refugees and undocumented workers, particularly from Latin American and Asia, will continue to come to Texas, in spite of the recent federal immigration initiative. Most communities expect growing difficulties in assisting them to integrate into U.S. society if citizenship becomes the major criteria for social services.

(e) Children and adolescents are a growing population among the homeless because of continued family disintegration. They are at severe high risk of all the aforementioned health problems: malnutrition, abuse, pregnancy, sexually transmitted disease, addiction and mental illness.

(7) GEOGRAPHIC DIFFERENCES - Texas' immense size and diversity insure that different regions and communities face different kinds of problems. The largest metropolitan areas (Houston, Dallas, Fort Worth, Austin and San Antonio) are seeing concentrations of vulnerable, severely ill mental patients and substance abusers, and some health care providers anticipate growing numbers of homeless AIDS victims. Smaller cities have growing rates of homeless families with health and other emergencies who have no place to live and no means to move to a larger urban areas. Some regions, such as South Texas, lack even basic shelter for the homeless. West Texas, particularly the Panhandle region, may have a larger percentage of transients than some other regions due to the impact of severe climate, unemployment and national highway networks.

Those cities which have formed homeless coalitions or task forces believe that their most important present need is to anticipate the impact of changing demographic characteristics of homeless people in their communities so that decision makers and service providers can prevent other families from losing their homes and the development of even more serious problems in the service delivery system. They emphasize the importance of coordination and cooperation among community advocates, directors of non-profit organizations, business people and elected officials for such efforts.

H. SUMMARY

What can be learned from these descriptions of homeless people in Texas? Research findings document the large number of needy people and community concerns, particularly about the mentally ill. The emergency shelter count shows that many homeless men have resources and are willing to work but are unable to find jobs. Homeless women appear to face different barriers to stabilizing their families and finding employment. The number of children in emergency shelters is a sobering indicator of the potential for continued family and community problems. The lack of information about street people's characteristics points out the need for additional research. The opinion survey documented that many local decision makers are not fully aware of the extent and diversity of needs among homeless people, but there was clear consensus about the importance of federal and state initiatives in affordable housing, employment and job training, emergency shelter and specialized health care services for the homeless. Site visit findings helped capture service deliverers' fears about continued increases in the homeless population, growing problems of drug abuse and violence, and the inability of local social services to respond. The next chapter outlines how Texas cities with homeless coalition groups developed primary health care models for homeless people in their communities.

Chapter IV V

CLOSING THE GAP: MODELS FOR RESPONSIVE COST-EFFECTIVE HEALTH CARE FOR HOMELESS PEOPLE IN TEXAS

> *The promise of relief from pain is a great motivator. Many alcoholics who deny any interest in treatment tend to be very responsive to medical attention when they are hurting. Demonstrated medical concern is one of the most effective ways to involve people in treatment.*
>
> Shandler, 1987

> *It would be erroneous and irresponsible to maintain that the numbers of homeless can be significantly reduced (or even eliminated) by addressing their problems from only a single point of intervention, particularly when one does not address concrete needs for decent housing, income support or vocational preparation . . . It also appears that service efforts will not be successful unless they are outreach oriented, non-traditional, and more acceptable to homeless persons than the office-centered services or referrals attempted in the past.*
>
> Mowbray, 1986

Support from foundations and the federal government resulted in the establishment of six homeless health care projects in Texas. Two have had time to test and refine their service delivery systems but are still working on administrative and research issues, while four are initiating their programs. From their experience and from findings of projects in other parts of the United States, we can identify the key elements of responsive, cost-effective health care services for homeless people.

A. THE TEXAS PROJECT OF THE ROBERT WOOD JOHNSON FOUNDATION AND THE PEW MEMORIAL TRUST

In March 1984, two major foundations announced their funding for a national Health Care for the Homeless demonstration program. The only homeless health care project awarded to a Texas community, that of San Antonio, was typical of most of the other new projects, in that it planned to develop shelter-based clinics to offer primary care services in two different neighborhoods adjacent to the downtown area. The model relied on a multi-disciplinary health team: a nurse practitioner, using medical protocols under a physician's supervision, was the primary administrator and on-site provider, and social workers and clerical workers assisted with the support services frequently needed by homeless people. Due to some management difficulties encountered by the community-based organization which received the Johnson-Pew grant, the local homeless coalition which had originated the project asked the United Way to assume administrative operations of the project. The United Way subcontracts for health care services with the local membership of the Daughters of Charity, an order of nuns dedicated to indigent health care which is headquartered in St. Louis. Since that implementation period, the project received a McKinney grant to expand its services.

B. HOMELESS HEALTH CARE PROJECTS IN TEXAS FUNDED BY THE STEWART B. McKINNEY ACT

In July 1987, the Stewart B. McKinney Homeless Assistance Act became the first comprehensive federal law providing emergency and support services to homeless people in the United States. Among its programs was a Primary Health Services category. It authorized $50 million and appropriated $46 million to fund non-profit agencies for up to 75% of the cost of providing emergency health services, outreach services, referral to mental health services, and aid to homeless people to obtain entitlement benefits and services. Grantees were encouraged to link with the mental health protection and advocacy organization in their states and to use consumer run mental health outreach programs (National Mental Health Association, 1987). Nine organizations in Texas applied for McKinney health funds, and six were funded in the following communities: San Antonio, Dallas, Fort Worth, Houston, Lubbock and Amarillo.

A brief outline of the major goals of each project shows important components in providing effective primary health care to homeless people in Texas. The projects in San Antonio and Dallas are unique, in that they had homeless health care services already under way for two years, and the McKinney funds allowed them to expand. For these reasons, they are presented in more detail than the other projects which only initiated their services in late 1987 or early 1988.

(1) San Antonio - This community had the base of a Johnson-Pew demonstration project to build on when it received a McKinney award. A local coalition had been working together for many months on developing a variety of local services to assist homeless people, and health care clinics had been operating at two emergency shelters since 1985. The service statistics are described in Chapter III.

The McKinney award supports a homeless outreach team which works to educate and involve caseworkers from social service agencies in assisting homeless people who are residing in the two downtown shelters. Thus, the McKinney outreach workers serve as coordinators of services and as advocates for the homeless in their attempts to extend the impact of shelter based clinics by helping those clients to obtain financial assistance, job training and other services to move them toward transitional housing.

Although the Homeless Health Care Project continues to follow a standard shelter-based health clinic model, the McKinney outreach component is unusual in that it also aims to identify and assist marginally housed people, especially women with children, who are at high risk of becoming homeless.

(2) Dallas - An active homeless coalition also developed in Dallas in response to the Johnson-Pew request for proposals. Their application was turned down by the two foundations, primarily because the reviewers believed that the Dallas community had the resources to undertake and support the proposed health care project without external support. After reviewing the situation, the City of Dallas decided to initiate a smaller project through its Health Department with assistance from Parkland Memorial Hospital, the county hospital district.

In March 1986, the City formed a Homeless Health Care Team and began basic primary care services in downtown emergency shelters and community kitchens. The original team consisted of a volunteer physician, several nurse practitioners, a caseworker and a secretary. Concern about the special needs of severely mentally ill homeless people who frequently did not use shelter services led other advocates to create the Community Outreach Coalition (COC). A mobile mental health team was hired by COC to assist mentally ill homeless people primarily in the downtown area.

During its first 18 months, the city health care team had almost 12,000 patient contacts (new and returning), with patients averaging slightly more than 3 visits each to the program. About 70% of their patients are men; the project initiated pediatric services in mid-1988 and does not yet have sufficient service statistics on homeless children and adolescents to analyze. Nearly 60% of all patients were White/Anglo, 33% were Black, and 8% were Hispanic. The nurse practitioner provided health care services in 42% of the encounters, while the primary provider was a physician 22% of the time, a psychiatric worker in 27% of the instances, and a social worker in nearly 9% of the contacts. The project does not yet have procedures for analyzing diagnostic services.

The COC mental health team assisted 613 mentally ill homeless people in the downtown Dallas area during its first 36 months of operation, 56% of whom were men. Statistics for the last two years show that nearly 73% were White/Anglo, 22% were Black, and about 5% were Hispanic. More than

58% had a prior hospitalization, with women having a slightly higher rate (61%) than men (56%). Less than 5% of the COC clients failed to keep their referrals, but 24% were identified by the staff as at risk and unwilling to accept services, while less than 1% had to be rehospitalized due to a life-threatening situation.

In the past, substance abuse was not a major focus of the homeless health clinics. The team members' awareness of alcohol and drug abuse increased with their experience in working with homeless people. Currently, a major concern is the very limited number of residential treatment slots available for the indigent care, because they believe that alcoholic and addicted homeless individuals are unlikely to benefit from outpatient therapy. The Dallas project administrators view the McKinney award as an important step in expanding homeless substance abuse service.

On receiving a McKinney award, the Homeless Health Care Team expanded to include an internal medicine physician administrator/service provider, a part-time pediatrician, a nurse practitioner who works as the nursing supervisor and a service provider, a family practice nurse practitioner, an emergency room liaison nurse, and a substance abuse worker. The project expanded its primary care services to other emergency shelters and feeding sites, and it added dental services, a substance abuse outreach component, pediatric screening and services. An additional goal, not yet realized, is to support a voluntary medically supervised detoxification center at the Salvation Army social services center, given that no such facility exists in Dallas County.

The Dallas homeless health care project is the largest, most expensive model in Texas. Its strengths include the breadth and comprehensiveness of care available to the homeless people who make use of its clinics, not all of which are based in shelters. The health care team worked with the City to develop a Day Resource Center so that homeless people would have a place to spend time when most shelters are not available to them. The second phase of renovation for the Day Resource Center hopes to expand the health care services available there, perhaps including visual refraction exams and dental care. Linkage with the mobile mental health unit permits quick and responsive help to the chronically mentally ill in ways that some of the other models do not. The availability of regular, consistent physician services means that both patients and other health care providers have an established relationship to build on, thus avoiding the problems that sometimes arise with the use of volunteer physicians who vary each week. The administrators report difficulties in recruiting nurse practitioners for the project.

(3) Fort Worth - The Fort Worth Health Department received a McKinney grant to establish a primary health care clinic for homeless people in the Presbyterian Night Shelter, a new emergency shelter which opened in the fall of 1987. In addition to the primary care services of the evening clinic, the Shelter assists local law enforcement officials by providing a site for temporary supervision of intoxicated individuals, and it has agreed to replace the local community mental health center in administering the only detoxification program available to indigent people beginning in late 1988. The Shelter has other space which can be adapted as new social service programs are added, and additional physical expansion may be possible if the community creates job development and child care services to assist homeless people seeking employment.

The homeless health care project model relies on the services of nurse practitioners, but it also uses volunteer physicians. The project has a unique advantage, however, in that the City Health Department provides the services of a Volunteer Coordinator, who works to ensure a regular schedule and more than adequate number of volunteers. This is an important point, as other indigent and homeless health care projects report that considerable staff time is required to contact and schedule volunteers to ensure clinic coverage.

Once the team completes its orientation training and the Shelter routines and protocols are well established, administrators plan to expand the shelter-based clinic services to other emergency shelters and to develop an outreach effort to reach homeless people not residing in shelters who are in need of health care.

(4) Houston - The Community Health Division of the Baylor College of Medicine administers the McKinney homeless health care project in Houston. Its proposal was assisted and supported by the homeless coalition which emerged out of the Johnson-Pew application process.

Plans are for primary health care clinics to be provided in all of the largest emergency shelters in the community, with a nurse practitioner leading a team which includes a social worker, a substance abuse caseworker, a research assistant and a clerk. Difficulties in recruitment have delayed the hiring of two additional nurse practitioners and a psychologist, who will expand the services and work with the community mental health center.

Emphasis is placed by the health care team on assisting homeless clients to become eligible for services through the Baylor community health centers. This is particularly effective in one instance where a family shelter is across the street from such a center; nevertheless, the "regular" clients place heavy demands on the centers for services, and most people have to wait, even with appointments.

One innovative administrative procedure by the Houston health care project greatly increased the availability of detoxification and substance abuse treatment services to homeless people in the area. The project does not require that the shelter-based clinics serve as the entry point or client eligibility site for services. It subcontracts with two substance abuse residential facilities and allows them to screen homeless people for services at their sites. Thus, the caseload of substance abusers in the Houston project is considerably higher than in other cities.

One substance abuse residential treatment facility, which has a reputation of being very strict (in its admissions criteria, its insistence on a two-year motivational commitment to the program by a potential client, and its program procedures), has preliminary data which suggest that homeless clients have similar or better retention rates than non-homeless residents in the first four to six months of treatment.

(5) Lubbock - The McKinney project in Lubbock aims to provide outreach services to homeless people to assist them in locating and using existing health care facilities in the community. An L.V.N. interviews visitors to the local community action agency to determine their eligibility. If they are homeless and in need of health care, she refers them to a low-income family health center or other health care providers, and the agency pays for any resultant services.

The project has assumed considerable responsibility in attempting to raise the awareness of local community and state agencies about the needs of homeless people in the area and the importance of coordinated services. Staff have assumed an active leadership role in supporting the local homeless advocacy coalition and also meet regularly with emergency shelter staff and other service providers to encourage community dialogue about how best to coordinate services.

(6) Amarillo - The Amarillo Hospital District formed the Panhandle Health Care Coalition to help identify innovative ways to deliver responsive, cost-effective health care to indigent people in the region. It received a McKinney award to initiate clinic-based health care services in two emergency shelters and the battered women's shelter, with the goal of providing primary health care in a more accessible manner to homeless people and of reducing expensive emergency room services. The project was unable to recruit a nurse practitioner but hired a nurse with public health experience.

Although Amarillo only has about 163,000 inhabitants, it is located on major interstate highways, and health care administrators believe that they serve a significant percentage of transients. By offering the services of an R.N. at the emergency shelters, they can screen more serious health care problems for appropriate referral to the medical school clinics and hope to treat minor illnesses or conditions that could become much more serious without attention. They also plan to develop documentation and cost analysis techniques which will help demonstrate the savings that can be realized by providing homeless primary health care services in the community.

C. KEY COMPONENTS OF RESPONSIVE, COST-EFFECTIVE HEALTH CARE SERVICES FOR HOMELESS PEOPLE

Findings from the literature review and the site visits identify the essential factors necessary to provide quality health care services to homeless people. The decision to serve people where they are located is the basic principle for effective projects. A homeless health care team must have a community health orientation, which implies that they are willing to go out to potential clients and to adapt their professional schedule to hours and sites that are accessible to their clients rather than requiring them to come to a hospital or medical office during an 8-to-5 timetable.

Staff attitudes and configurations determine the direction and success of a homeless project. Team members who come from different disciplines must be highly professional, yet dedicated and flexible in their ability to deal with the limitations and the potentially positive aspects of a community location. A mobile, nurse-practitioner model predominates and offers real promise to both inner-city neighborhoods and rural areas by offering a lower cost means of filling gaps in public health care, thus expanding the number and scope of community clinics. Some of the teams include individuals from diverse racial/ethnic backgrounds, and a few have bilingual English-Spanish providers, an especially important qualification for Texas programs.

Almost all of the projects report difficulties in recruiting individuals who agree with the program orientation and are interested in working with homeless patients. Particularly, there is a shortage of nurse practitioners. People mentioned noncompetitive salaries, the fact that the State of Texas does not permit nurse practitioners to function as broadly as some other states, and the cost of malpractice liability insurance that nurse practitioners have to carry just as physicians do. Yet the teams formed by the Texas projects demonstrate considerable camaraderie and excitement as they create a new type of service for a previously excluded group of people. New team members sometimes need special training in public or community health concepts and supervision or assistance to adapt to the unusual features of homeless outreach and shelter-based clinics. Careful criteria for staff selection and training results in the formation of a multidisciplinary and creative team with a common purpose.

A homeless health care team usually functions best when it is based at a central clinic but operates additional services at several outlying sites to deal with screening, outreach and referrals. Strong and positive relationships with a local hospital district and/or university medical school ensure that the backup emergency care is accessible and also that homeless people who use emergency room services can be alerted to the possibility of alternative primary health care services in the future.

An essential feature of effective homeless health care projects is a vigorous, visible outreach program. Health care team members develop ways to locate and communicate with homeless people in addition to shelter residents, and the health care team members also play an important role in alerting social service agencies to the needs of homeless people and how they might be served more effectively.

Many homeless advocates and health care team members believe that aggressive case management is the key to services for homeless people in their communities. Clinical health services must relate to other support services that can help homeless people to move out of dependency. Most homeless people believe that their basic problem is unemployment: with a job, they are willing to try to obtain the housing, food and health care they need. While this may not be completely realistic in some instances, the importance of advocacy on behalf of homeless people and their need for employment and affordable housing cannot be separated from homeless health care services.

The goal is to identify and eliminate or reduce barriers to health care delivery and social services. State and local criteria which define residence, for example, can serve as insurmountable barriers to services for homeless people. One county may require documentation for 30 days residence in addition to intent to reside, while others may accept residence in an emergency shelter. Language barriers, whether in reception or treatment, make effective service delivery very difficult; the lack of bilingual, particularly Spanish- English, health care professionals continues to be a major problem in Texas. Transportation remains a barrier to services for many homeless people; most programs believe they resolve this by providing clients with bus tokens. Many women have problems in keeping appointments due to difficulties in finding someone to care for their infants and children. Lack of follow-up research about reasons for failure to keep appointments does not provide information about transportation issues (limited service, long waits between transfers, complexity of routes, difficulties in reading schedules, problems of taking children on buses, etc.) or other barriers faced by low-income people.

Most homeless health care projects have a social worker to assist their clients to locate and use other community services. Some have been more successful in emphasizing employment counseling than others. State agencies with vocational programs for adults, such as the Texas Rehabilitation Commission and the Texas Employment Commission, could play an important role in extending their service accessibility to homeless people by exploring possibilities for linking up with the on-site health care projects. This is also true of the Texas Department of Human Services, as well as city and county human service programs, in terms of assisting the homeless to determine their eligibility for Medicaid, SSI, AFDC and other state or federal assistance programs.

Both the literature and the experience of homeless health care projects document the importance of coordinating with local mental health service programs. Many of the Texas homeless health care projects report some frustration in this respect because of the new statewide emphasis on targeting the chronically or severely mentally ill and the extraordinary client overload reported by most community mental health centers. The shelter-based clinics can screen and refer individuals, but they often cannot access treatment services.

Another key component is the need for effective linkage with substance abuse treatment facilities and after-care programs, with an emphasis on outreach contact and on developing local residential programs sensitive to the needs and limited resources of homeless people. This is probably the weakest element of the Texas homeless health projects, only because many Texas cities effectively do not have public detoxification facilities for indigent people other than jails, and the very few residential treatment programs open to indigent persons have such long waiting lists as to deny treatment.

Early physical health screening when combined with distribution of needed medication and other treatments on site appear to be two essential features for effective homeless health care. While it is important to establish trust and to respond to the expressed medical concerns of homeless clients, working in an appropriate fashion to emphasize the importance of taking care of oneself and of the need for assessing physical health serves multiple purposes within the shelter environment (e.g., including TB screening as a routine procedure). Making medicines and prescription drugs immediately available to homeless patients increases the probability of their following through with the appropriate treatment, whereas referring them to another site for prescriptions further complicates their efforts to get health care services.

Finally, in terms of governance and administrative issues, research on the 19 Johnson-Pew homeless health care projects around the nation concluded that a continuing role of advocacy for homeless people by local coalition groups is important. Separate governing boards should be developed to administer and run the program, with the staff carrying out the day-to-day tasks. The major factor in holding down per-client costs is increasing the volume of clients, a difficult challenge for homeless health projects in smaller cities and rural areas. Continuation funding must be anticipated from the beginning of the project. Networking is helpful in order to develop transition processes for the homeless health care programs to be integrated into existing delivery systems. Several Johnson-Pew projects have already been incorporated into city health departments.

The national administrative review of homeless health care demonstration projects concluded with several recommendations for project planners and administrators:

1) Encourage flexibility in local models;
2) Incorporate regular program evaluation into operations;
3) Allow for failure and modification of service plans;
4) Combine health care with social services;
5) Identify priorities early and develop an adaptable goal-setting process;
6) Build in burn-out prevention activities for the staff;
7) Continue advocacy efforts to raise awareness about homeless issues;
8) Work on developing and maintaining community relations with a wide variety of groups and organizations; and
9) Provide client-centered, individualized treatment.

D. SUMMARY

Several major points about local services arise from this review of Texas homeless health care projects. The problems of homeless people vary in different regions, and a variety of community-based models that responds to local needs and local resources are appropriate. Nevertheless, the advantages of a multidisciplinary health care team working in a shelter-based clinic, with the nurse practitioner being the primary service provider, are apparent, both in terms of responsiveness and cost-effectiveness. The shortage of nurse practitioners and their concerns about their professional stature and malpractice issues, however, indicate potential problems with provider availability. In addition, the potential for learning about community health care and homeless people may not be realized if the Texas projects do not receive technical assistance and funds to support a systematic research effort that examines both service statistics and implementation issues. Finally, without extension of Medicaid coverage and probably some additional long-term financing of indigent health care, it is unlikely that most communities will be able to finance such local homeless health care initiatives. Thus, Texans will have to consider several important policy issues in order to decide how best to develop homeless health care services in their state.

Chapter V

POLICY IMPLICATIONS FOR TEXAS

From a policy perspective, the homeless are doubly problematic. In the first instance, they are evidence of the failure of the service model in practice, people who have not been reached, or who fail to avail themselves of assistance in the form in which it is offered. They are casualties of a "system" whose promises far outstrips its capacity to deliver.

Baxter & Hopper, 1981

Some shelter operators provide austere accommodations and few social services because they believe homeless families -- many headed by single mothers on welfare -- will stay forever if shelters are too comfortable... yet...the so-called bed-of-nails policy has backfired. The Spartan shelters, not the service-rich facilities, tend to draw the homeless for months and sometimes years on end.

Whitman, 1988

What should be the roles and responsibilities of the public and private sectors in Texas with respect to homeless health care services? To answer this question, four factors must be analyzed. We must first decide on several key issues relating to the state's health care delivery system, including indigent health care, alcohol and drug abuse treatment services, and community care for the mentally ill. A second factor to be assessed is the impact of federal and state eligibility criteria on the availability of health and social services. A third is the need for coordination among governmental agencies to serve homeless people more effectively. The fourth, and final, factor concerns the direction of future research on homeless people in Texas. These key factors and how they are addressed will help guide our decisions about the role of government and that of community groups to meet the emergency and long-term needs of homeless people and to prevent other individuals and families from becoming homeless.

A. KEY ISSUES FOR POLICY FORMATION

INDIGENT HEALTH CARE IN TEXAS - Most homeless people in Texas live in urban areas with county hospitals or hospital districts which are responsible for providing health care to low income residents. It is left to each institution, however, to determine the characteristics of the medically indigent, and as a result, decisions about who qualifies for indigent health care vary widely from county to county and from hospital district to hospital district. In addition, Texas leads the nation in the number of investor-owned and privately managed hospitals, which provide less than 1% of the charity care in our state (Task Force on Indigent Health Care, 1984). Therefore, county hospitals, public hospital districts, and nonprofit hospitals absorb the cost of almost all indigent health care, including services to homeless patients. This situation is, of course, not unique to Texas (Bazzoli, 1986; Government Research Corporation, 1988). Counties in Texas without a public hospital or hospital district have new responsibilities to pay for indigent health care of people who intend to reside there (Hudson, Rosenbaum and Lanham, 1985). One additional concern is that indigent health care services in Texas provide considerable acute care but do not concentrate sufficiently on primary care.

(1) Primary Health Care for Homeless People - The most comprehensive study of homeless health care issues to date concludes that homelessness exposes a large and growing segment of urban populations to highly elevated health risks and, therefore, should be attacked as any other environmental hazard: *"as a matter of urgent national priority."* Nevertheless, the authors point out that there are probably not more than a million homeless people in the United States at any one point in time, whereas at least 6% of the national population generally cannot obtain medical care due to their poverty status. Therefore,

> *Better access to health care for homeless Americans is only the first step in what one hopes will prove to be a renewed national commitment to quality health care for all, even for the poorest among us.* (Wright & Weber,1988, p. 159)

Even when primary care services are available in a community, structural barriers in the health care services delivery systems can block access of homeless individuals. They often do not have the resources (information, mobility, motivation) to tackle the complex intake system except in emergencies. A program's commitment to reviewing system policies and regulations with the objective of increasing access can make a difference, and the nurse-practitioner model operating in several sites will be effectively utilized. The other key component is integrated eligibility procedures and assertive case management to link primary health care to needed social services, substance abuse, and mental illness care.

(2) Substance Abuse and Treatment Services - The same authors conclude that alcohol abuse, especially among homeless men, is perhaps the single largest health problem of the homeless population. In almost every community visited during the course of this research project, local health care providers expressed deep concern about growing polydrug/alcohol abuse and the lack of public services for detoxification, treatment and recovery of indigent substance abusers. The lack of facilities meant that there was little possibility of services for homeless people.

(3) Mental Illness Services - National research also suggests that, next to substance abuse, mental illness is the second leading health problem within the homeless population and that it is an especially widespread problem among homeless women. Many mentally ill homeless people need a 24-hour, supervised care environment: *"Abandonment should not be misconstrued as liberation"* (Wright & Weber, 1988, p. 157). Mental health advocates in Texas argue that the failure to provide State funding to communities to develop a variety of residential care settings, coordinated by effective case managers, results in severely mentally ill individuals ending up among homeless street people and being victimized.

(4) Sexually Transmitted Diseases, Intravenous Drug Use, and AIDS - Several homeless service providers reported their fears about sexually transmitted disease (STD) and, in particular, AIDS, which is transmitted both through sexual behaviors and intravenous drug use. Awareness about these public health concerns arises from a recognition of demographic changes among homeless people: in general, they are younger, there are more Black and Hispanic homeless individuals, and many more women, adolescents and children are becoming homeless than in the past. These groups are at high risk of STD's and AIDS because of their poverty, their lack of information about preventive health care and their vulnerability to sexual abuse, unplanned pregnancy and chemical addiction. In addition, AIDS victims are at high risk of becoming homeless because of loss of employment and limited health care benefits as their disease progresses.

(5) Implications for Services - Do we want to recommend that every Texas city should attempt to implement a shelter-based homeless health care project? The federal McKinney projects in Texas demonstrate the responsiveness of different local institutions and agencies (city health departments, medical schools, hospital districts, and community-based organizations) in taking primary health care to homeless people in their cities. The solid achievements of local homeless health care projects, however, like most health care services, can best be characterized as crisis intervention. Such efforts do not and cannot represent an adequate solution to the more basic problems of education, job skills and employment, nor can they address services for substance abusers or the severely mentally ill. In addition, unless they are integrated into systems to

provide indigent health care, they could end up with eligibility criteria that block the recently homeless and the marginally housed from services which they desperately need.

These Texas projects are federally funded on an annual basis with little or no guarantees for long-range provision of services. At this point, they represent a separate or parallel form of primary care, offering services to the homeless for the first time. We need federal and state policies that clarify our responsibilities in the indigent health care field and that permit the incorporation or development of homeless health care services within that policy framework.

FEDERAL AND STATE ELIGIBILITY CRITERIA FOR HEALTH AND SOCIAL SERVICES - The growing numbers of homeless families, and in particular women as single parents with dependent children, lend an element of urgency to the need for state and local program adaptation. Homeless research documents that most women with dependent children tend to be first-time, episodic or short-term homeless and have the best prospects for the future if they are quickly assisted to pull out of their crises. On the other hand, without short-term help, they are most likely to become long-term AFDC recipients and, with the current low-income housing crisis, part of a permanent underclass (Bassuk, Rubin & Lauriat, 1986). The effects of homelessness on the physical and psychological well-being of the children and their risk of becoming substance abusers unable to participate in society effectively suggest the importance of special programs to assist them and their parents as rapidly as possible (Wright & Weber, 1988). The Texas Department of Human Services, for example, could shorten the waiting period of qualification and assess the impact of other structural barriers to AEDC and other services, thereby easing the suffering of these mothers and their children. Streamlining the application and certification processes and giving such women special priority for housing and child care subsidies could be a priority. Similar efforts on behalf of mentally ill individuals would insure that pre-release procedures are organized so that an ex-patient receives SSI benefits upon discharge (American Public Health Association, 1985).

One important finding of a major national study on homeless health care was that the presumed under-utilization of public benefits by homeless people was not as widespread as the authors had anticipated.

About half of their clients were receiving some form of benefit assistance (somewhat higher among women than among men and increasingly higher for older people). However, there was extraordinary variation across the 19 cities studied; the authors concluded that this resulted primarily from state-level differences in assistance eligibility criteria. Therefore,

> *Efforts to improve the entitlement picture for the nation's urban homeless . . . need to be directed to state legislatures more than to local welfare offices.* (Wright & Weber, 1988, p. 144)

This is particularly true in Texas, where the State does not use full Medicaid and other federal assistance benefits. For example, extending AFDC assistance to certifiable two-parent families would not make much difference in terms of the actual cash benefits, yet it would make the adults eligible for health care, job training and child care services which have the potential of assisting those economically dislocated families to get back on their feet. Nonetheless, even with the broadest Medicaid program currently possible, it would still not be possible to serve adults aged 18 to 65 who do not have children or adults in two-parent families (except for pregnant women) unless they are blind or permanently disabled. Thus, Texas, like all the states, must continue to explore with the federal government other options to provide health care services to uninsured people, as well as coverage for catastrophic illness and injury (Hudson, Rosenbuam & Lanham, 1985).

THE NEED FOR COORDINATION AMONG FEDERAL AND LOCAL AGENCIES TO SERVE HOMELESS PEOPLE IN TEXAS - "Homelessness" is an ambiguous concept, and many programs expend considerable energy in attempting to define it in order to decide whether or not a needy individual or family qualifies for public assistance. Certification of eligibility for public assistance is a formidable task for almost all low-income people. A homeless individual who does not have the typical documents of normal life has even more difficulty. National research on homeless health care suggests that we need to escape such a posture and move toward:

> *. . . a system of health care for the homeless, the near homeless, the marginally housed, the obviously destitute, the medically under-served, and more or less anyone else who appears to need health care that they evidently cannot afford.* (Wright & Weber, 1988, p. 154)

Such an effort must participate in and support a coordinated system of service delivery, linking its efforts to those of other local service providers, including mental health, substance abuse, housing, child care and employment. For such local coordination to occur, a renewed spirit of commitment and cooperation in serving low-income individuals must emerge at the state and federal levels. Many eligibility regulations were designed to exclude people rather than to serve people in need effectively.

Site visit interviews suggested that cooperative efforts among State agencies to create a system of integrated eligibility for low-income and indigent people would be a tremendous accomplishment for both clients and service providers. Recommendations included the development of consensus about basic eligibility criteria and the possibility of a single eligibility form that could be used across programs, thus permitting a low-income person to be determined eligible at any one social service agency and not be subjected to repetitive and difficult certification processes over and over. Some local health care programs have opened up a number of small eligibility offices throughout the community to make it easier to certify people before they have health care emergencies. Several people suggested the use of computerized identification cards and sharing of data banks in order to make it easier to serve low-income people.

When asked about possible issues of confidentiality and fraud, service providers concluded that low-income people would be subjected to much less invasion of privacy and indignities in the eligibility certification process and possible efforts to obtain benefits inappropriately could be monitored more effectively if technological advances similar to those of banking and industry were incorporated into social services. To accomplish such goals, federal and state agencies would have to coordinate their policies and become more efficient. Such efforts would make it easier at the local level to develop multi-service assistance centers which emphasize appropriate referrals and to foster a holistic approach to individuals in need.

FUTURE RESEARCH ON HOMELESS PEOPLE IN TEXAS - One assessment of the development of homeless policy research suggests that an over-emphasis on counting and describing homeless people has supported the growth of local charitable emergency services but has inhibited planning for more fundamentally needed structural changes in state and national policies. The author concludes that narrowly conceived and poorly utilized research findings block effective pursuit of more appropriate service and prevention strategies. He recommends that more attention should be directed to comparing and evaluating different service models which explicitly target the reintegration of the homeless; designing feasibility and cost-benefit studies of alternative service models; and developing empirical models which analyze a range of national, state and local policies and demographic factors to explain variations in homeless populations in different localities (Hudson, 1988).

Research also needs to continue to analyze barriers to services, utilization patterns, and quality of care issues (Council on Research and Development, American Hospital Association, 1986). An initial step would be to clarify the definition of a homeless individual by Texas and local government agencies so that basic service delivery statistics can be analyzed. More structured research in both urban and rural areas of Texas which studies the situations and needs of special populations would help ensure that the diversity of homeless people is understood. Some combination of federal, State and private sector funding is also required to document and learn more about the policy and service delivery implications of McKinney-funded homeless health care projects and should be an immediate priority for Texas.

A distinct issue arises from our rather limited understanding of how homeless people cope with their desperate circumstances. Research needs to focus somewhat less on the predictable despair and mental stress of homeless people and document more of their coping strategies and competencies (Rivlin, 1985). Using such information to modify service delivery procedures will make the entire process of serving the homeless much more effective. From a service delivery planning perspective, we need to learn considerably more about the simple day-to-day life of homeless persons; answers to such questions (how long does it take to ride the bus from the clinic to the county hospital where prescriptions are filled; what kind of protection is available for adolescent females in shelters; how do different homeless groups talk about AIDS) will allow service providers to develop more effective and cost-efficient services. For example, learning about the use of alcohol and other drugs to mute the strain and misery of homelessness offers opportunities to develop more effective intervention and treatment programs (Fagan & Mauss, 1987; Wright, James, 1985). Furthermore, careful and professional screening procedures with clearly defined criteria must be used before attributing mental illness to a homeless individual.

B. THE ROLE OF THE PUBLIC SECTOR

As data from the Texas community opinion survey show, local decision-makers in Texas cities believe that there is a strong role for the public sector, and they linked homeless health care issues to the need for affordable housing in Texas. A state task force documented the need for decent, safe and sanitary housing units within the economic reach of all Texans; to meet these criteria, a housing unit must have:

1. adequate space, ventilation, insulation and illumination for the people who reside there;
2. adequate and safe water sources and wastewater facilities to ensure the residents that the water they drink and use for cooking and washing will not make them ill, and that human waste will be properly disposed of, regardless of the weather; and
3. a quality of construction and of materials to protect residents (e.g., the unit can be maintained, the paint on the walls will not make them ill, and vermin and insects cannot enter). (TDCA Task Force on Affordable Housing, 1987, p. 5-6)

The major issues in planning for affordable housing in Texas include: an initial goal of maintaining and rehabilitating of our dwindling supply of existing low-income housing stock; the relevance of helping community leaders and taxpayers to recognize the relationship of home construction industries to local employment and economic prosperity; the need for community support of publicly subsidized housing for those families unable to obtain home ownership; the importance of assisting low-income families to move toward home ownership; and the necessity of providing other social supports to assist those potential home owners (public transportation, child care, job training, and quality education). Several suggestions for policy development are outlined below.

THE FEDERAL GOVERNMENT - Current federal assistance for homeless people can be characterized primarily as emergency monies to address the most basic of crises. Community Development Block Grant money is being phased out, and continuing cuts with regard to support services and low-income housing are anticipated unless there is a significant change in public policy (Schussheim, 1986). Although there is support for continued emergency funds to assist communities, many homeless advocates conclude that the greatest contribution the federal government could make would be to recommit its funds and technical assistance to developing, restoring and maintaining safe, decent low-income housing (Keyes, 1988; National Housing Task Force, 1988).

In terms of national health policy, unless the federal government generates a clearer commitment to health care as a right similar to that of education, little major changes can be expected. One possibility might be broader mandates in extension of Medicaid coverage. Given the federal deficit and demands for other services, any immediate resolution to these issues is probably unlikely

Nevertheless, there appears to be growing public support for a much more assertive and efficiently coordinated federal alcohol and drug abuse prevention campaign, although a consensus about its focus has yet to emerge. A national planning effort and assistance to state and local program design, materials development, training and research will be necessary to address the complex interrelationships of this major health problem. The results can assist community groups which want to develop local treatment services for homeless people.

Another example of the crucial support role of the federal government is the 1990 Census Shelter/Street Night Enumeration Plan. Its objective is to provide a count of different groups of the homeless or transient population and to establish a residence rule concept consistent with the concept of usual home (Miskura, 1988).

STATE GOVERNMENT - It would thus appear that state and local governments must assume major leadership for indigent and homeless people's health care. The primary responsibility for resolving issues of indigent health care in our state will lay with the Texas Legislature. Some county hospitals and hospital districts are overwhelmed by the health care needs of indigent families. Some county governments fear that their State-mandated 10% allocated funds will be quickly exhausted by indigent people's medical emergencies. Many city governments conclude that if they had more funding for their preventive and primary health care efforts, fewer crises would wind up in the emergency rooms of public hospitals, thus resulting in significant tax savings. The only viable option appears to be the development of a more equitable and efficient State system that would guarantee health care to all Texas residents regardless of income or residence and that would define preventive health care as a major priority. If coupled with expanded benefits for Medicaid/Medicare, SSI and AFDC, homeless people and other low-income families would be more likely to pull themselves out of crisis.

LOCAL GOVERNMENTS - The first responsibility of county and city governments is to assess the operations of their public health care services provided through county hospitals and hospital districts. Evaluating the degree to which those services are "user-friendly" will be the first step in reducing and eliminating barriers. Local governments can also allocate matching funds and technical assistance to non-profit community-based organizations to offer health care services to homeless people and other indigent groups. In addition, the public sector can work to create innovative partnerships with both for-profit and non-profit organizations to develop support services that foster education, job training and employment for needy individuals who use their health care programs.

People interviewed during the site visits emphasized the importance of greater coordination among government programs to serve homeless people. This is especially relevant for State Government because there is no specific Texas agency in charge of homeless issues.

C. COMMUNITY RESPONSIBILITY AND ADVOCACY

Nationally, homeless advocates are documenting the need for broad community leadership and volunteerism which will draw on the expertise of business people, urban planners, church and neighborhood leaders, and other community residents to prevent further homelessness. They view coordination of services as the major priority (American Psychiatric Association Task Force, 1984; Brickner, 1985; Newton & Duffy, 1987; Schwab, 1986).

Most Texans believe that community-based, non-profit organizations should play a significant role in assisting homeless people -- both in terms of sheltering them and of assisting them to move out of crisis. There is considerable debate on where the emphasis should be and how local coalition efforts can assist each organization to function most effectively. In many larger Texas cities, agreement is growing that enough emergency shelters have been built or renovated to provide meals and sleeping space at night. Coalitions which came together in the face of the desperate needs of homeless people in the last five years are now trying to determine whether they should continue and, if so, what should be their role and objectives.

Several groups are moving on to other issues, for example, to develop child care support for AIDS victims. Others believe that emergency shelter is only the most basic need of homeless people and that local coalitions must find ways to create and support literacy and other basic education services, job training, employment services, transitional housing and development of affordable housing. Most agree that every Texas urban area needs additional and more diverse programs for substance abusers and severely mentally ill individuals. Several Texas cities, however, have not yet formed homeless coalitions or created emergency shelters for needy individuals. Clearly, these are essential first steps before other efforts can be developed.

One major gap in service delivery across the state are youth programs. Given the high dropout rate that characterizes Texas schools and the resulting unemployment of adolescents and young adults, our youth are at great risk of becoming permanently underemployed and possibly homeless. The rates of alcohol and drug abuse are increasing, including changing patterns with multi-substance experimentation and the more widespread use of such particularly dangerous substances as crack and inhalants. Shelter directors and youth service workers worry about the growing apathy, family disintegration, physical self-destruction and social violence among inner city young people in Texas. They are the potential homeless of the next 20 years -- unless we decide to create realistic options for them to participate productively in society by transforming our schools and our communities to give them opportunities to work.

D. SUMMARY

Conflicts between different levels of service providers can generate one additional barrier to care for homeless people: we need to decide whose responsibility it is to address their needs. The homeless become a city problem if they are identified primarily as potential welfare or human services clients, whereas they become a state problem if they are perceived primarily as mentally ill (Stern, 1984). Our major task is to clarify the responsibilities of our public agencies and to move on in meeting the needs of homeless people in our state.

It was sobering to hear the director of an emergency shelter in a downtown warehouse talk about his growing realization that he could no longer pretend to be doing rehabilitation work with the homeless. He had come to accept the fact that the facility he managed was the end of the line for most of the people who ended up there. The director stated quietly that he was prepared to give them shelter each night and to help some of them struggle with terminal illnesses and die with dignity. Amazingly, he concluded by insisting that he didn't want more funding for the shelter: what he wanted was money for good day care services, preschool programs and elementary schools.

> *We can't handle many more people down here; unless we can give the younger ones a reason for living and the skills to find work, it's all going to break apart.*

Chapter VI

THE FUTURE OF TEXAS:
INVESTING IN OUR PEOPLE TO PREVENT HOMELESSNESS

The major victims of homelessness are . . . children, who, with their families, are forced to live under the most desperate conditions -- in overcrowded shelters or welfare hotels.

Rivlin, 1985

Many Texans think the homeless are a very serious or somewhat serious problem in the state, and a majority think the problem is worse than in the past . . . Texas' sagging economy has eliminated many jobs, pushing many families into the streets and jamming shelters for the homeless . . . When asked whether the state should spend tax revenue to help the homeless, 73 percent said yes . . .

Dyer, 1988

Homeless people in Texas are correct in their hunch that no government program can adequately house and feed their families; they must be able to earn a wage and pay their own expenses as they go, for their own benefit and for the future well-being of our state and of our nation. Housing and health care cannot be separated from the most widely documented desire of most homeless people: employment and job skills. Business people aware of the changing demographics of our country recognize that children deprived of an adequate education are disadvantaged in a society requiring high levels of literacy and skills to survive. In planning for future business growth and development in the 21st century, business leaders are recognizing the possibility of a severe employment crisis: a

> *"scarcity of well educated and well qualified people in the work force will seriously damage this country's competitive position in an increasingly challenging global marketplace"* (Committee for Economic Development, 1987).

In a study undertaken at the request of the Texas Legislature's Select Committee on Tax Equity, the authors concluded that:

> *Unless the work force is equipped to earn adequate wages and pay corresponding levels of taxes, it is likely that our state will face a revenue shortage of a far greater magnitude in the coming century.* (Friedholm & Team, 1988, p. 11)

The most recent national task force on housing characterized the homeless as "a problem that won't wait:"

> *While there is honest disagreement over the number of homeless Americans, we know that the homeless population is growing and that this is intolerable in a nation whose standard of living is the envy of the world.* (National Housing Task Force, 1988, p. 9)

The group concluded that because homelessness is a many-faceted problem which varies widely from community to community, the best solutions will be designed at the local level. They urged the allocation of federal funds to states and communities to assist the homeless and to prevent other families and individuals from losing their homes. In addition, the group recommended funding of local coalitions - partnerships of local governments, the private sector and non-profit institutions - to create comprehensive systems of assistance to homeless people.

Local governments and advocacy coalitions in Texas have focused on emergency services to provide assistance to individuals and families in crisis, but they cannot address the social system factors which contribute to continuous waves of homeless people in their communities. Such systemic change will require planning and commitment at the state level to move from such a reactive position of crisis intervention to a more effective role of prevention.

Thus, the State of Texas can most effectively prevent homelessness by allocating more technical assistance and funds for investment in its human capital -- the health care, education and job training of Texans to make them able to earn their own way and capable to lead productive, independent lives.

Appendix A

PROJECT STAFF, LIAISON PEOPLE, AND ADVISORY GROUP MEMBERS

STAFF AND AGENCY LAISON PEOPLE

STAFF

Sister Mary Sapp, Executive Director
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San Antonio

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STAFF AND AGENCY LAISON PEOPLE

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Program for the Homeless
United Way of San Antonio & Bexar County
San Antonio

Estela DeAnda, MSW - Executive Director
Mujeres Unidas/Women Together
McAllen

Rev. Richard Duncan, D. Min. - Executive Director
Corpus Christi Metro-Ministries
Corpus Christi

Carol Frank - Director
Social Services
Salvation Army
Dallas

Dr. Virginia Moyer - Director
Health Care Group, Homeless Project
and Assistant Chief of Community Medicine Services
Baylor College of Medicine
Houston

Lori C. Renteria
Austin Homeward Bound
Austin

Linda Saucedo - Director
Tarrant County Department of Human Services
Fort Worth

Betsy Schwartz - President
Coalition for the Homeless
Houston

Sam Silva - Manager
Employment and Social Services
Guadalupe Economic Service Corporation
Lubbock

Mary E. Stefl, Ph.D.
Department of Health Care Administration
Trinity University
San Antonio

Rev. Wayne Thornton - Executive Director
Rescue Mission of El Paso
El Paso

Appendix B

RESEARCH DESIGN AND PROCESS

RESEARCH DESIGN AND PROCESS

A. LITERATURE REVIEW

Project staff searched several major social science and health literature computer data banks, including Psychological Abstracts, Sociological Abstracts, Drug Info and Alcohol Use and Abuse, Health Planning and Administration, MEDLARS, Nursing and Allied Health Literature, and Social Work Abstracts. In addition, we obtained homeless bibliographies from the Community Information Exchange, the Clearinghouse on Homelessness among Mentally Ill People .(CHAMPS), and the Robert Wood Johnson Foundation. Almost 200 separate articles, chapters, documents and reports were abstracted into an electronically retrievable format to study national information on homeless problems and health care services in the United States and Texas.

B. CENSUS OF EMERGENCY SHELTER RESIDENTS

This counting process relied on the cooperation of emergency shelter administrators, staff, and volunteers to interview residents in selected shelters. The form, in English and Spanish, follows. Each resident was asked the 11 questions, and he or she responded anonymously.

The census took place on the evening of February 22, 1988, in 15 cities, with 43 shelters participating. A few shelters had difficulty in interviewing on that specific night and did so the following evening. The counting process did not necessarily occur in all shelters in all cities, as it was not always possible to obtain complete lists, and some shelter directors chose not to participate for a variety of policy and logistical reasons.

A number of women's centers did not receive their forms and were not able to participate. For that reason and in order to expand the sample of women, the project invited the entire membership of the Texas Council on Family Violence, which includes 64 battered women's shelters, to participate in a second count on April 18, 1988, using the same form and procedures. The April interviews replaced those of the few women's shelters which participated in the February census; thus, there were no duplicated cases. This process added 17 other cities, 37 shelters and

182 women. Thus, there were a total of 3,113 individuals who were interviewed in 80 shelters. (although not every individual responded to all questions). Table 1 documents the geographic distribution of the shelters which participated.

Some shelters were more successful in obtaining the participation of residents than others. While it is difficult to estimate the exact refusal rate across shelters, we estimate that about 90% of the residents did participate. The figures do not necessarily represent an exact count of people sleeping at the shelters that evening, however. Some shelter administrators chose to interview all people waiting to enter (including some who planned only to eat and then to leave), while others focused solely on those who would be sleeping there.

Although Spanish forms were made available to the shelters, less than 3% (n = 83) of the interviews were recorded on the Spanish forms. For example, only 13 Spanish forms were returned from the South Texas region, with only one (1) coming from San Antonio. Subsequent site visit interviews showed that this probably does not reflect language preferences of shelter residents but is rather an indicator of a general lack of bilingual staff and volunteers.

The women in emergency shelters (n = 511) differed in several ways from those in family crisis and battered women's shelters (n = 239). In addition to those characteristics mentioned in Chapter 3, women in emergency shelters were less likely to be Native Texans, yet the non-Native women in emergency shelters had been in Texas for an average of more than 8 years. These emergency shelter residents were concentrated in the East and Northeast of the state. The majority of women in family crisis battered women's shelters had first used a shelter in the last 12 months. They were more evenly distributed throughout the state, but this probably reflects the widespread existence of women's shelters and the less even distribution of emergency shelters in Texas.

It is important to remember that the findings from this shelter census process cannot serve as an accurate number or count of homeless people in Texas since it only included selected cities, nor of homeless people in the represented cities, because the findings do not include homeless individuals who were street people, those who were staying in automobiles, jails and prison, paid rooms or other non-domestic places, nor those residing with family and friends temporarily.

In addition, the responses represent information as directly reported by the people in the shelters; the information may or may not be accurate. For example, the author interviewed one individual on crutches with a bandaged foot that insisted that he was "able to work" if only jobs were available in the community. Similarly, with some exceptions, very few respondents identified mental health or substance abuse problems as barriers to their employment, which does not seem to fit with information from other research.

Finally, the results reflect one specific point in time and thus were subject to influences such as the mild weather throughout Texas on that evening, a particularly unusual condition for the state's northern areas. Nevertheless, the results can help us understand the characteristics of homeless individuals in Texas, and the implications challenge us to learn more from homeless people in our state. Tables 2 through 11 in Appendix C report the analyses of the interviews.

Shelter Count of Texas Homeless

Date__________

Sponsored by the Texas Homeless Network

City____________________________ Shelter_____________________________ Volunteer's Initials____________

1. Gender: Male Female **2. Date of Birth?**_______________ **3. Are you a veteran?** Yes No

4. What is your racial background or ethnicity? Are you Hispanic?

Non-Hispanic	Hispanic
_____Anglo or White	_____Mexican or Mexican American
_____Black or Afro-American	_____Cuban or Cuban American
_____Native American	_____Other:_________________________ Name of country
_____Other: ______________________	

5. What was the last grade in school that you completed?

_____Less than 8th grade

_____Finished 8th grade

____Some high school

____Finished high school

If finished high school, ask → _____Some college

_____Finished college

6. How long ago did you first ever use a shelter?_______________(days, wks, mos, yrs.)

7. How long have you been in Texas?_____________(days, wks, mos, yrs.)

8. How long have you been here in this city?_____________(days, wks, mos, yrs.)

9. How long ago did you first come to this shelter?_____________(days, wks, mos, yrs.)

10. Are you here with family or friends, or are you alone in this shelter. Alone Friends Adult family Children

If accompanied → **Not counting yourself, how many adults are here with you?**_________

How many children?_________ **How old are they?** Girls _____ _____ _____ _____

Boys _____ _____ _____ _____

11. Are you working right now? Full time Part time Day labor No

If No → **Is there anything that stops you from being able to work right now?** No Yes Uncertain

If yes or Uncertain → **What?**____

Fecha ________________

CENSO DE LUGARES DE ALOJAMIENTO EN TEXAS PARA PERSONAS SIN HOGAR

Patrocinado por el Texas Homeless Network

Ciudad ______________________ Programa ____________________ Initiales del Voluntario ____________

1. Sexo M F 2. **¿Fecha de nacimiento?** ________________ 3. **¿Es Ud. veterano?** SI No

4. ¿Cuàl es su origen nacional o cultural?

_____ Los Estados Unidos (PREGUNTALE QUE ES EL ORIGEN NACIONAL DE SU FAMILIA, Y INDIQUE LA RESPUESTA ABAJO)

_____ Mèxico _____ Cuba _____ Otro país: __________________

5. ¿Cuàl fuè el ultimo grado escolar que Ud. cumpliò?

_____ Menos que 8 años _____ Parte de secundaria _____ Estudios universitarios

_____ Cumpliò 8 años _____ Cumpliò secundaria _____ Graduò de universidad

6. ¿Cuànto tiempo hace desde la primera vez que Ud. pasò la noche en un lugar de alojamiento (shelter)? ____________________ (días, semanas, meses, años)

7. ¿Cuànto tiempo ha estado Ud. en Texas? ______________ (días, semanas, meses, años, siempre)

8. ¿Cuànto tiempo ha estado en esta ciudad? ______________ (días, semanas, meses, años, siempre)

9. ¿Cuànto tiempo hace que llegò Ud. aguí a este lugar de alojamiento?
____________________ (días, semanas, meses, años)

10. ¿Està Ud. aguí con familia o compañeros? o ¿Està solo/a en este lugar?
Solo/a Compañeros/as Familia: Adultos/as Niños

SI ES ACOMPANADO/A: ♦ **¿Cuàntos adultos estàn aguí con Ud.?** ________________
¿Cuàntos niños? ____________
¿Cuàntos años tienen? Niñas ____ ____ ____ ____
Niños ____ ____ ____ ____

11. ¿Tiene Ud. trabajo ahora? Tiempo completo Medio tiempo Trabajo de vez en cuando No

SI NO: ♦ **¿Hay algo que no le permita a Ud. poder trabajar ahora?** No SI Incierto/a

SI RESPONDE QUE SI O INCIERTO: ♦ **¿Què es?** ____

____

C. OPINION SURVEY OF KEY DECISION-MAKERS

The Benedictine Center mailed an opinion survey regarding community service needs of homeless people in Texas to 584 key decision-makers in the 31 most populated cities of the state (the form follows this section). The categories of respondents included: (1) direct service providers to homeless people and homeless advocates (directors of shelters, food programs, homeless health clinics); (2) local and regional health and human service administrators (local health departments, hospitals, community mental health centers, substance abuse treatment programs, human services offices, rehabilitation programs); and (3) community leaders (mayors, county judges, presidents of the local medical association and chambers of commerce, directors of United Way, religious leaders).

Table 12 summarizes the number and type of the 301 respondents to the survey (a 51.5% return rate). Community leaders did not respond to the same degree as service providers or administrators, and some cities had lower response levels than others. However, there is a roughly equivalent distribution of responses across the five geographical regions of the state. Tables 13 through 23 in Appendix D report the analysis of their responses.

Benedictine Health Resource Center
600 East Anderson Lane #636
Austin, Texas 78752

SURVEY ON HEALTH CARE NEEDS OF HOMELESS PEOPLE IN TEXAS

Do not write in this column

1. Describe the **CURRENT CHARACTERISTICS OF HOMELESS PEOPLE IN YOUR COMMUNITY**. Please RANK THE TWO LARGEST GROUPS in a thru d:
Majority or largest group = 1st; Second largest group = 2nd. | ___ 1 ___ 2

a. Age and Gender
(1) Adult men age 20 - 40
(2) Adult men age 40 - 55 | ___ 3 ___ 4 ___ 5
____ (3) Adult women age 20 - 40
1st (4) Adult women age 40 - 55
(5) Adult women w/children under 18 | ___ 6
(6) Adolescent males (age 12 - 19)
____ (8) Adolescent females w/children
2nd (9) Families (adult man, adult woman & children) | ___ 7
(10) Children (age 11 or under) by themselves
(11) Elderly individuals (age 56 or older)
(12) Others________________________________
(13) Uncertain

b. Ethnic/Racial Background
(1) White or Anglos (non-Hispanic)
____ (2) Blacks (non-Hispanic) | ___ 8
1st (3) Hispanics
(4) American Indian
____ (5) Others:________________________________
2nd (6) Uncertain | ___ 9

c. Educational Status
(1) Less than 8th grade
(2) Completed 8th grade
____ (3) Some high school | ___ 10
1st (4) Completed high school
(5) Vocational or technical training
____ (6) Some college | ___ 11
2nd (7) College graduate
(8) Other:________________________________
(9) Uncertain

d. Health Status/Work Ability
(1) Able to work
____ (2) Physically able but mentally/emotionally disabled | ___ 12
1st (3) Physically unable to work
(4) Unable to work because of alcohol/drug abuse
____ (5) Other:________________________________ | ___ 13
2nd (6) Uncertain

2. Do you see **ANY CHANGES IN RECENT YEARS IN THE CHARACTERISTICS** of the homeless population in your community?

_____(1) Yes _____(2) No _____(3) Uncertain ___

14

If YES, indicate any GROUPS WHICH SEEM TO BE **INCREASING** in your community. Please check as many as apply.

a. **Age and Gender**

_____ (1) Adult men age 20 - 40
_____ (2) Adult men age 40 - 55 15 16 17
_____ (3) Adult women age 20 - 40
_____ (4) Adult women age 40 - 55
_____ (5) Adult women w/children under 18 18 19 20
_____ (6) Adolescent males (age 12 - 19)
_____ (8) Adolescent females w/children
_____ (9) Families (adult man, adult woman & children) 21 22 23
_____(10) Children (age 11 or under) by themselves
_____(11) Elderly individuals (age 56 or older)
_____(12) Others_______________________ 24 25 26
_____(13) Uncertain

b. **Ethnic/Racial Background** 27

_____ (1) White or Anglos (non-Hispanic)
_____ (2) Blacks (non-Hispanic) 28 29 30
_____ (3) Hispanics
_____ (4) American Indian
_____ (5) Others:_______________________ 31 32 33
_____ (6) Uncertain

c. **Educational Status**

_____ (1) Less than 8th grade 34 35 36
_____ (2) Completed 8th grade
_____ (3) Some high school
_____ (4) Completed high school 37 38 39
_____ (5) Vocational or technical training
_____ (6) Some college
_____ (7) College graduate 40 41 42
_____ (8) Other:_______________________
_____ (9) Uncertain

d. **Health Status/Work Ability**

_____ (1) Able to work
_____ (2) Physically able but mentally/emotionally disabled 43 44 45
_____ (3) Physically unable to work
_____ (4) Unable to work because of alcohol/drug abuse
_____ (5) Other:_______________________ 46 47 48
_____ (6) Uncertain

3. What are the **MOST IMPORTANT UNMET NEEDS OF HOMELESS PEOPLE** in your community? Please check as many as apply.

____ (1) Food and nutrition
____ (2) Clothing
____ (3) Emergency shelter
____ (4) Affordable Housing
____ (5) Employment
____ (6) Job Training
____ (7) Literacy and basic education
____ (8) Transportation
____ (9) Child care
____(10) Medical care
____(11) Mental Health care
____(12) Alcoholism services
____(13) Drug abuse services
____(14) Other________________
____
____
____
____(15) Uncertain

__ __ __ 49 50 51
__ __ __ 52 53 54
__ __ __ 55 56 57
__ __ __ 58 59 60

4. From your answers to Question #3, **WHAT ARE THE THREE MOST IMPORTANT NEEDS TO MEET THE LONG-RANGE WELL-BEING OF PERSONS** in your community.
Please list in order (1 = most important).

(1)____

(2)____

(3)____

__ __ __ 61 62 63
__ __ __ 64 65 66

5. What are your perceptions of the **MAJOR HEALTH CARE PROBLEMS OF HOMELESS PEOPLE** in your community?
Please check as many as apply.

____ (1) Infestations (lice, scabies, etc.)
____ (2) Exposure (due to lack of shelter or clothing)
____ (3) Trauma (resulting from serious injuries)
____ (4) Infections (respiratory, gastrointestinal, skin, muscles)
____ (5) Hypertension & other cardiovascular diseases
____ (6) Peripheral vascular disease (leg ulcers, varicose veins)
____ (7) Tuberculosis
____ (8) Tooth & dental problems
____ (9) Eye & visual problems
____(10) Ear and hearing problems
____(11) Reproductive & genito-urinary problems (pregnancy, birth control, organ disorders)
____(12) Sexually transmitted diseases, and AIDS
____(13) Alcoholism and other substance abuse
____(14) Long-term mental illness
____(15) Chronic physical disability or handicap
____(16) Malnutrition & dietary related problems
____(17) Other________________________________
____(18) Uncertain

__ __ __ 67 68 69
__ __ __ 70 71 72
__ __ __ 73 74 75
__ __ __ 76 77 78
__ __ __ 79 80 81
__ __ __ 82 83 84

6. Does your community have a **SIGNIFICANT PROBLEM IN PROVIDING HEALTH CARE SERVICES** to homeless people?

____ (1) Yes ____ (2) No ____ (3) Uncertain

Please explain your response.________________________________
____
____

__ 85
__ 86

7. **WHAT IS MOST NEEDED** in your community to provide health care for homeless people? Check as many as apply.

___(1) Outreach programs to help homeless people use existing services
___(2) Mobile units to take health care services to the homeless
___(3) Ambulatory or walk-in clinics in appropriate areas to offer health care services for homeless people
___(4) Caseworker at local public hospital assigned to assist the homeless to use existing hospital services
___(5) Special mental health services for homeless people
___(6) Special alcohol & substance abuse services for the homeless
___(7) Other________________________________
___(8) Uncertain

___ ___ ___
87 88 89

___ ___ ___
90 91 92

___ ___
93 94

8. From the list in Question #7, what are the **THREE MOST NEEDED HOMELESS HEALTH CARE SERVICES** in your community? Please list in order (1 = most important).

(1) ________________________________

(2) ________________________________

(3) ________________________________

___ ___ ___
95 96 97

9. **WHO SHOULD PROVIDE THOSE HEALTH CARE SERVICES** to homeless people in your community? Check as many as apply.

___(1) Up to the homeless individual to get services
___(2) Religious and other private charity organizations
___(3) United Way (local community supported agencies)
___(4) Physicians and other private health care providers
___(5) City government
___(6) County government
___(7) State government
___(8) Federal government
___(9) Other________________________________
___(10) Uncertain

___ ___ ___
98 99 100

___ ___ ___
101 102 103

___ ___ ___
104 105 106

___
107

10. From the list in Question #9, which groups or agencies should have the **MAJOR RESPONSIBILITY TO PAY FOR HEALTH CARE SERVICES** of homeless persons in your community? Please list in order (1 = major responsibility).

(1) ________________________________

(2) ________________________________

(3) ________________________________

___ ___ ___
108 109 110

11. In your community, has any local government or community group ever formed a **Task Force or local coalition to assist homeless people?**

___ (1) Yes ___ (2) No ___ (3) Uncertain

___
111

IF YES, please describe its activities and major findings -- OR-- give a contact address or phone number.

D. SITE VISITS

The project research coordinator and administrator scheduled 14 site visits to clarify findings from the emergency shelter count and the mail survey, and to learn more about the implementation processes of both; to collect additional data on health care needs of homeless persons in different regions of the state; and to document in greater detail local services and health care delivery models of Texas communities.

The process involved one to three trips of one to two days each to major metropolitan areas, particularly those which had a federally funded homeless health care project. The project staff interviewed key local decision makers, including homeless advocates and service providers, other health care personnel, health and human service administrators and providers, and local leaders, including several individuals who participated in the shelter count and the mail survey. They also observed the facilities and operations of shelters, clinics, homeless outreach programs, emergency rooms, etc. They reviewed archival and other written materials, in order to obtain service statistics and other pertinent information for later analysis. They also attended meetings of local coalition groups and other activities in several of the communities.

The schedule of site visits included:

February	8, 1988	Houston
April	11-13	Houston
	18-19	San Antonio
	26-27, 29	Lubbock
	28	Amarillo
May	4-5	Corpus Christi
	5-6	McAllen, Edinburg & Harlingen
	9-10	Fort Worth
	11-12	Dallas
	18-20	El Paso
	23-24	San Antonio
June	1-3	Houston
	7	Fort Worth
	8-9	Dallas

A list of the 193 individuals who were interviewed is in Appendix E.

Appendix C

TEXAS SHELTER CENSUS OF HOMELESS PEOPLE
DATA TABLES 1-11

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS SHELTER CENSUS OF HOMELESS PEOPLE - 1988

Table 1

Regional Distribution of Shelters Which Participatied

-Region-	No. Shelters Contacted	% Shelters Participation (Number)	No. of Cities Represented
State Total	100	81% (81)	34
EAST	25	88% (22)	5
NORTHWEST	24	83% (20)	12
CENTRAL	11	73% (8)	6
SOUTH	16	88% (14)	6
WEST	24	71% (17)	5

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS SHELTER CENSUS OF HOMELESS PEOPLE - 1988

Table 2

Race/Ethnic, Gender and Age Characteristics of Adults

Percentage (Number)

RACE/ETHNICITY	Percent	(Number of Respondents*)
White/Anglo	49.7%	(1409)
Black	28.3%	(802)
Hispanic	18.0%	(510)
American Indian	3.0%	(85)
Non-Hispanic Other	1.0%	(30)
TOTAL	100.0%	(2836)
GENDER		
Male	74.0%	(2098)
Female	26.0%	(738)
TOTAL	100.0%	(2836)
AGE (Years)		
19 and younger	2.4%	(62)
20 - 39	57.5%	(1464)
40 - 55	28.5%	(727)
56 - 65	9.5%	(242)
66 and older	2.0%	(52)
TOTAL	99.9%	(2547)

* The number of respondents varies because some individuals did not answer every question. Columns may not sum to 100% due to rounding.

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS SHELTER CENSUS OF HOMELESS PEOPLE - 1988

Table 3

Age Distribution by Race/Ethnicity of Adults*

	White Anglo	Black	Hispanic	American Indian	Uncertain -Other-
19 or Under	2.2% (30)	0.8% (6)	6.0% (28)	2.7% (2)	3.5% (1)
20 - 39	49.0% (658)	69.2% (524)	61.8% (290)	47.3% (35)	69.0% (20)
40 - 55	32.7% (438)	23.7% (179)	23.7% (111)	36.5% (27)	27.6% (8)
56 - 65	13.8% (185)	4.9% (37)	6.8% (32)	8.1% (6)	-0- -0-
66 +	2.2% (30)	1.5% (11)	1.7% (8)	5.4% (4)	-0- -0-
TOTALS	99.9% (1341)	(757)	(469)	(74)	(29)

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS SHELTER CENSUS OF HOMELESS PEOPLE - 1988

Table 4

Age Distribution of Children

	Percent	(Number)
Infants - 1 year	19.6%	(123)
2 - 3 years	22.2%	(140)
4 - 5 years	18.0%	(113)
6 - 11 years	29.6%	(186)
12 - 14 years	7.6%	(48)
15 - 18 years	3.0%	(19)
Total	100.0%	(629)

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS SHELTER CENSUS OF HOMELESS PEOPLE - 1988

Table 5

Current Work Status by Race/Ethnicity and Gender of Adults

In Percent*

	White/Anglo		Black		Hispanic	
-Current Work Status-	Male	Female	Male	Female	Male	Female
Full-time Employed	11.1	12.5	9.2	14.6	8.0	15.1
Part-time Employed	10.9	9.6	11.4	10.0	10.5	12.1
Day Labor	9.1	5.1	12.4	4.0	13.6	1.5
Unemployed	68.9	72.7	66.9	71.3	67.9	71.2
TOTAL	100.0	99.9	99.9	99.9	100.0	99.9
Number of Respondents	(1000)	(352)	(577)	(199)	(324)	(132)

* Columns may not sum to 100% due to rounding

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS SHELTER CENSUS OF HOMELESS PEOPLE - 1988

Table 6

Statewide Summary of Selected Characteristics by Race/Ethnicity and Gender of Adults

	White/Anglo		Black		Hispanic		American Indian		Other	
-Characteristics-	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Mean Age (Years)	42.6	35.1	37.3	33.5	37.3	29.9	35.8	31.1	43.6	30.8
Mean Time in Texas for Non-Natives (Years)	8.9	8.8	8.5	7.2	6.8	7.5	6.2	8.1	8.8	4.8
Percent Veterans	51.9%	5.8%	31.3%	3.3%	18.1%	4.8%	39.1%	5.9%	17.6%	-0-
Percent Native Texans*	30.9%	36.5%	41.4%	48.2%	38.8%	58.0%	33.8%	23.5%	17.6%	20.0%
Percent High School Graduates	56.2%	56.0%	54.1%	69.1%	21.7%	30.7%	41.7%	50.0%	70.0%	50.0%
Percent Currently Unemployed	68.9%	72.7%	66.8%	71.3%	67.9%	71.2%	85.0%	90.0%	68.2%	100.0%
Percent Reporting "Able to Work"	62.0%	45.8%	67.8%	45.0%	68.9%	52.2%	56.1%	53.3%	47.1	70.0

*Native Texans are defined as those persons reporting having lived in Texas before age 7.

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS SHELTER CENSUS OF HOMELESS PEOPLE - 1988

Table 7

Regional Comparisons - Time of Residence in Texas of Adults*

Percentage (Number)

Region	STATE TOTALS	EAST	NORTHEAST	CENTRAL	WEST	SOUTH
Total Numbers	100.0% (2815)	31.3% (882)	35.2% (990)	5.5% (154)	12.4% (350)	15.6% (439)
Native Texans	37.1% (1044)	38.8% (342)	33.9% (336)	42.9% (66)	33.1% (116)	41.9% (184)
Long-term Residents	21.7% (610)	27.7% (244)	22.3% (221)	17.5% (27)	14.9% (52)	15.0% (66)
Short-Term Residents	9.9% (278)	10.0% (88)	10.5% (104)	11.0% (17)	7.4% (26)	9.8% (43)
Recent Arrivals	31.4% (883)	23.6% (208)	33.2% (329)	28.6% (44)	44.6% (156)	33.3% (146)

* Native Texan - lived in Texas since before age 7

Long-term Resident - 2 years or more residence in Texas

Short-term Resident - 1 - 2 years residence in Texas

Recent Arrivals - lived in Texas 12 months or less

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS SHELTER CENSUS OF HOMELESS PEOPLE - 1988

Table 8

Reported Barriers to Employment by Race/Ethnicity and Gender of Adults*

(In Percent)

-Barriers-	White/Anglo		Black		Hispanic	
	Male	Female	Male	Female	Male	Female
Physical Health	**50.0**	**30.2**	**50.0**	**27.9**	**29.5**	**14.8**
Mental Health	7.6	8.8	**15.7**	**17.4**	6.4	3.7
Substance Abuse	2.1	1.2	2.1	1.2	5.1	-0-
Pregnancy	-0-	**10.7**	-0-	12.8	-0-	9.2
Education	3.3	8.8	5.7	12.8	2.6	**14.8**
No Jobs/Poor Economy	**18.0**	7.5	**17.8**	8.1	**26.9**	-0-
Age	7.3	4.4	0.7	3.5	3.8	1.8
Discrimination	0.3	-0-	2.1	-0-	1.3	-0-
No Day Care	0.3	**19.5**	-0-	**15.1**	-0-	**35.2**
No Transportation	**10.9**	9.4	6.4	3.5	5.1	**16.7**
No ID or Documentation	1.8	1.9	0.7	-0-	**15.4**	9.2
No Domicile	2.1	3.8	1.4	3.5	1.3	1.8
Other	3.3	6.3	2.8	2.3	5.1	3.7
Number of Respondents	(328)	(159)	(140)	(86)	(78)	(54)

* **BOLD** = The three major barriers for each Race/Ethnic-by-Gender group in response to the open-ended question, "Is there anything that stops you from being able to work right now? Columns do not sum to 100%, as respondents could report up to three barriers.

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS SHELTER CENSUS OF HOMELESS PEOPLE - 1988

Table 9

Duration of Homelessness - Statewide Distribution on Time Elasped

Since First Use of Any Shelter by Adults

First Use of Any Shelter	Percent	(Number of Respondents)
Less than 1 month	28.3	(760)
1 month to 6 months	14.7	(395)
6 months to 1 year	16.7	(448)
1 year to 2 years	10.3	(276)
2 years to 5 years	15.8	(425)
Over 5 years	14.2	(381)
TOTAL	100.0	(2685)

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS SHELTER CENSUS OF HOMELESS PEOPLE - 1988

Table 10

Regional Comparisons of Race/Ethnic and Gender Characteristics of Adults

Percentage/Number*

-Characteristics-	EAST		NORTHEAST		CENTRAL		WEST		SOUTH	
	%	N	%	N	%	N	%	N	%	N
Race/Ethnicity										
White/Anglo	41.9	(372)	54.6	(527)	57.4	(135)	61.1	(206)	41.0	(169)
Black	44.1	(391)	30.9	(299)	11.1	(26)	11.9	(40)	11.2	(46)
Hispanic	9.9	(88)	10.2	(98)	27.7	(65)	22.6	(76)	44.4	(183)
American Indian	2.9	(26)	3.4	(33)	3.8	(9)	3.3	(11)	1.5	(6)
Non-Hispanic Other	1.1	(10)	0.8	(8)	-0-	-0-	1.2	(4)	1.9	(8)
TOTAL	99.9	(887)	99.9	(965)	100.0	(235)	100.1	(337)	100.0	(412)
Gender										
Male	71.3	(632)	76.5	(738)	81.3	(191)	68.6	(231)	74.2	(306)
Female	28.7	(255)	23.5	(227)	18.7	(44)	31.4	(106)	25.7	(106)
TOTAL	100.0	(887)	100.0	(965)	100.0	(235)	100.0	(337)	99.9	(412)
Age										
19 and younger	1.7	(14)	1.9	(18)	0.7	(1)	3.3	(11)	5.4	(23)
20 - 39	57.4	(480)	55.8	(530)	59.4	(85)	56.9	(189)	59.8	(254)
40 - 55	28.8	(241)	30.1	(286)	24.5	(35)	29.2	(97)	25.2	(107)
56 - 65	8.7	(73)	11.5	(109)	9.8	(14)	8.7	(29)	8.7	(37)
65 and older	3.4	(28)	0.7	(7)	5.6	(8)	1.8	(6)	0.9	(4)
TOTAL	100.0	(836)	100.0	(950)	100.0	(143)	99.9	(332)	100.0	(425)

* Columns may not sum to 100% due to rounding.

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS SHELTER CENSUS OF HOMELESS PEOPLE - 1988

Table 11

Regional Summary of Selected Characteristics of Adults

-Characteristics-	STATE TOTALS	EAST	NORTHEAST	CENTRAL	WEST	SOUTH
Mean Age (Years)	38.4	39.2	38.7	39.0	37.6	36.4
Mean Time in Texas for Non-Natives (Years)	8.4	10.9	8.2	7.6	5.5	6.1
Percent Veterans	30.6	28.2	31.9	34.0	31.7	31.4
Percent Native Texans*	37.2	38.9	33.9	43.7	33.9	42.9
Percent High School Graduates	53.3	54.0	54.9	53.0	52.9	48.7
Percent Currently Unemployed	69.7	72.4	65.9	65.7	71.3	71.7
Percent Reporting "Able to Work"	59.9	57.3	61.4	45.0	65.4	63.7

* Native Texans are defined as those persons reporting having lived in Texas since before age 7.

Appendix D

COMMUNITY SURVEY
DATA TABLES 12-22

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS COMMUNITY OPINION SURVEY ABOUT SERVICES FOR HOMELESS PEOPLE

TABLE 12

Perceived Characteristics of Local Homeless
Number of Respondents by City and Catageory*

CITIES	Advocates & Direct Service PROVIDERS	Health & Human Service ADMINISTRATORS	Community LEADERS
Houston	8 (9)	14 (19)	3 (9)
Dallas	7 (9)	8 (20)	3 (9)
San Antonio	6 (8)	13 (13)	4 (9)
Ft. Worth	6 (9)	5 (12)	2 (7)
Arlington	0 (0)	2 (5)	1 (2)
Austin	4 (6)	8 (12)	2 (8)
El Paso	3 (3)	7 (12)	3 (7)
Beaumont	4 (6)	3 (8)	1 (6)
McAllen	1 (3)	3 (4)	5 (8)
Corpus Christi	2 (4)	7 (11)	3 (6)
Brownsville	0 (1)	1 (5)	2 (5)
Lubbock	4 (5)	7 (10)	2 (7)
Galveston	0 (2)	6 (6)	6 (7)
Amarillo	4 (8)	5 (10)	3 (7)
Waco	2 (3)	6 (10)	3 (7)
Tyler	1 (1)	4 (6)	2 (7)
Odessa	0 (2)	3 (7)	2 (7)
Wichita Falls	0 (1)	5 (10)	4 (7)
Abilene	1 (3)	6 (5)	3 (6)
Bryan	1 (3)	5 (8)	2 (6)
Laredo	0 (0)	3 (4)	1 (2)
Midland	1 (4)	2 (7)	1 (9)
Port Arthur	2 (2)	4 (6)	1 (6)
Edinburg	0 (3)	3 (9)	1 (5)
Harlingen	1 (1)	5 (4)	3 (3)
Temple	0 (0)	8 (12)	1 (8)
Texas City	0 (1)	2 (2)	2 (2)
Longview	1 (2)	4 (7)	3 (7)
Sherman	1 (4)	5 (7)	2 (6)
San Angelo	3 (6)	6 (10)	1 (7)
Victoria	2 (3)	3 (8)	2 (9)
TOTALS	65 (112) [58.0%]	162 (271) [59.8%]	74 (201) [36.8%]

Total surveys distributed: 584 [100%]
Total surveys returned: 301 [51.5%]

* The number in parentheses indicates the number of surveys mailed to respondents in that category.

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS COMMUNITY OPINION SURVEY ABOUT SERVICES FOR HOMELESS PEOPLE

Table 13

Perceived Characteristics of Local Homeless by Respondent Category

	TOTAL		Advocates/ Service PROVIDERS		Health & Human Services ADMINISTRATORS		Community LEADERS	
Population Groups	%	N	%	N	%	N	%	N
I. **AGE/GENDER**								
Adult men 20-40	45.2	(136)	50.8	(33)	44.4	(72)	41.9	(31)
Adult men 41-55	29.2	(88)	16.9	(11)	34.6	(56)	28.4	(21)
Adult women 20-40	1.7	(5)	3.1	(2)	1.2	(2)	1.4	(1)
Adult women 41-55	0.7	(2)	-0-	(-0-)	1.2	(2)	-0-	(-0-)
Adult women with children	9.0	(27)	20.0	(13)	3.7	(6)	10.8	(8)
Adolescent males	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)
Adolescent females with children	0.7	(2)	1.5	(1)	0.6	(1)	-0-	(-0-)
Families	4.0	(12)	4.6	(3)	2.5	(4)	6.8	(5)
Children Alone	0.3	(1)	-0-	(-0-)	-0-	(-0-)	1.4	(1)
Elderly	3.3	(10)	-0-	(-0-)	4.3	(7)	4.1	(3)
Uncertain/Other	3.6	(11)	-0-	(-0-)	4.9	(8)	4.1	(3)
II. **RACE/ETHNIC**								
White/Anglo	58.8	(177)	58.5	(38)	61.7	(100)	52.7	(39)
Black	15.3	(46)	15.4	(10)	14.8	(24)	16.2	(12)
Hispanic	19.9	(60)	21.5	(14)	16.0	(26)	27.0	(20)
American Indian	0.3	(1)	1.5	(1)	-0-	(-0-)	-0-	(-0-)
Uncertain/Other	4.3	(13)	-0-	(-0-)	6.8	(11)	2.7	(2)

Table 13 continued...

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS COMMUNITY OPINION SURVEY ABOUT SERVICES FOR HOMELESS PEOPLE

Table 13, continued

Perceived Characteristics of Local Homeless by Respondent Category

	TOTAL		Advocates/ Service PROVIDERS		Health & Human Services ADMINISTRATORS		Community LEADERS	
Population Groups	%	N	%	N	%	N	%	N
III. **EDUCATION**								
0-8 Years	49.5	(149)	43.0	(28)	59.4	(80)	55.4	(41)
9-11 Years	31.9	(96)	43.0	(28)	27.2	(44)	32.4	(24)
High School Grad.	6.0	(18)	10.8	(7)	5.6	(9)	2.7	(2)
Vocational Degree	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)
Some College	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)
College Degree	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)
Uncertain	11.0	(33)	1.5	(1)	16.0	(26)	8.2	(6)
IV. **HEALTH STATUS & WORK ABILITY**								
Able to Work	39.5	(119)	60.0	(39)	29.0	(47)	44.6	(33)
Unable -								
Mental Illness	36.9	(111)	27.7	(18)	43.2	(70)	31.1	(23)
Physical Disability	2.0	(6)	-0-	(-0-)	1.9	(3)	4.1	(3)
Alcohol/Drug Abuse	13.6	(41)	3.1	(2)	19.1	(31)	10.8	(8)
Uncertain/Other	6.3	(19)	7.7	(5)	5.6	(9)	6.8	(5)
Number of Respondents		(301)		(65)		(162)		(74)

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS COMMUNITY OPINION SURVEY ABOUT SERVICES FOR HOMELESS PEOPLE

Table 14

Perceived Characteristics of Local Homeless by Region

	EAST		NORTH/EAST		CENTRAL		WEST		SOUTH	
Population Groups	%	N	%	N	%	N	%	N	%	N
I. AGE/GENDER										
Adult men 20-40	50.9	(29)	52.6	(30)	50.0	(21)	40.0	(26)	38.6	(27)
Adult men 41-55	29.8	(17)	24.6	(14)	26.2	(11)	30.8	(20)	31.4	(22)
Adult women 20-40	-0-	(-0-)	7.0	(4)	-0-	(-0-)	1.5	(1)	-0-	(-0-)
Adult women 41-55	-0-	(-0-)	1.8	(1)	-0-	(-0-)	-0-	(-0-)	1.4	(1)
Adult women with children	5.3	(3)	5.3	(3)	11.9	(5)	15.4	(10)	7.1	(5)
Adolescent males	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)
Adolescent females with children	-0-	(-0-)	-0-	(-0-)	2.4	(1)	1.5	(1)	-0-	(-0-)
Families	3.5	(2)	1.8	(1)	-0-	(-0-)	4.6	(3)	7.1	(5)
Children Alone	-0-	(-0-)	1.8	(1)	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)
Elderly	3.5	(2)	-0-	(-0-)	2.4	(1)	-0-	(-0-)	8.6	(6)
Uncertain/Other	1.8	(1)	5.3	(3)	7.1	(3)	4.6	(3)	1.4	(1)
II. RACE/ETHNIC										
White/Anglo	54.4	(31)	77.2	(44)	71.4	(30)	60.0	(39)	42.9	(30)
Black	38.6	(22)	14.0	(8)	14.3	(6)	13.8	(9)	-0-	(-0-)
Hispanic	-0-	(-0-)	1.8	(1)	7.1	(3)	18.5	(12)	55.7	(39)
American Indian	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)	1.5	(1)	-0-	(-0-)
Uncertain/Other	1.8	(1)	7.0	(4)	7.1	(3)	4.6	(3)	1.4	(1)

Table 14 Continued. . .

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS COMMUNITY OPINION SURVEY ABOUT SERVICES FOR HOMELESS PEOPLE

Table 14, continued

Perceived Characteristics of Local Homeless by Region

	EAST		NORTH/EAST		CENTRAL		WEST		SOUTH	
Population Groups	%	N	%	N	%	N	%	N	%	N
III. EDUCATION										
0-8 Years	43.9	(25)	40.4	(23)	42.8	(18)	52.3	(34)	60.0	(42)
9-11 Years	40.4	(23)	35.1	(20)	28.6	(12)	35.4	(23)	22.9	(16)
High School Grad.	3.5	(2)	8.8	(5)	7.1	(3)	1.5	(1)	10.0	(7)
Vocational Degree	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)
Some College	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)
College Degree	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)
Uncertain	7.0	(4)	15.8	(9)	21.4	(9)	7.7	(5)	7.2	(5)
IV. HEALTH STATUS & WORK ABILITY										
Able to Work	35.1	(20)	36.8	(21)	33.3	(14)	43.1	(28)	44.3	(31)
Unable -										
Mental Illness	47.4	(27)	29.8	(17)	42.9	(18)	26.2	(17)	42.9	(30)
Physical Diability	-0-	(-0-)	-0-	(-0-)	-0-	(-0-)	3.1	(2)	4.3	(3)
Alcohol/Drug Abuse	10.5	(5)	22.8	(13)	14.3	(6)	20.0	(13)	4.3	(3)
Uncertain/Other	3.5	(2)	8.8	(5)	9.6	(4)	6.1	(4)	4.1	(2)
Number of Respondents		(57)		(57)		(42)		(65)		(70)

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS COMMUNITY OPINION SURVEY ABOUT SERVICES FOR HOMELESS PEOPLE

Table 15

Perceived Changes in Characteristics of Local Homeless People

A. Percent of all Respondents Reporting Any Change in Recent Years

	Percent	Number
Change	71.7	(210)
No Change	11.3	(33)
Uncertain	17.0	(50)
	100.0	(293)

B. Top Two Groups Which Have Increased

	Percent
AGE/GENDER	
- Adult Women with Children	39.9
- Families (Adult Man, Adult Woman and Children)	37.2
RACE/ETHNICITY	
- White/Anglo	46.5
- Hispanic	39.9
EDUCATION	
- Some High School (9-11)	33.9
- High School Graduate	25.2
HEALTH STATUS/WORK ABILITY	
- Disabled-Mental Illness	46.8
- Able to Work	43.2

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS COMMUNITY OPINION SURVEY ABOUT SERVICES FOR HOMELESS PEOPLE

Table 16

Perceptions of Health Problems of Local Homeless People

(Percent of respondents identifying each problem)

Health Problem	Percent
Alcoholism/Drug Abuse	83.1
Dental Problems	67.8
Chronic Mental Illness	62.1
Infections	53.8
Malnutrition/Dietary Disorder	47.2
Exposure	39.2
Sexually Transmitted Disease	33.2
Infestations	29.6
Physical Diability	25.2
Visual Problem	24.6
Hypertension/Cardiovascular Disease	23.9
Reproductive/Genito-Urinary Disease	23.3
Trauma	20.6
Tuberculosis	14.3
Peripheral Vascular Disease	13.0
Hearing Problems	11.0
Uncertain	9.0

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS COMMUNITY OPINION SURVEY ABOUT SERVICES FOR HOMELESS PEOPLE

Table 17

Most Important Unmet Needs for the Long-Range Well-Being of Homeless People

(Rank Order of State Total and by Respondent Category)*

Ranking

	TOTALS	Advocates/ Service PROVIDERS	Health & Human Service ADMINISTRATORS	Community LEADERS
Affordable Housing	1.24	1.57	1.12	1.22
Employment	1.04	1.19	.93	1.15
Shelter	.60	.55	.66	.51
Job Training	.42	.25	.39	.62
Medical Care	.41	.31	.45	.42
Food/Nutrition	.36	.20	.36	.50
Mental Health Care	.33	.39	.38	.18
Literacy/Education	.23	.15	.18	.41
Alcohol Treatment	.18	.17	.19	.18
Child Care	.17	.35	.09	.18
Transportation	.14	.11	.20	.05
Drug Treatment	.08	.12	.07	.09
Clothing	.05	-0-	.07	.05
Uncertain	-0-	-0-	-0-	-0-

* Score reported = mean ranking on a scale from a maximum value of 3 to a minimum value of 1. About 5% of the responses identified other needs; these were not included in the ranking procedure.

TEXAS COMMUNITY OPINION SURVEY ABOUT SERVICES FOR HOMELESS PEOPLE

Table 18

Most Important Unmet Needs for the Long-Range Well-Being of Homeless People

(Regional Rank Order)*

RANKING

UNMET NEEDS	EAST	NORTHEAST	CENTRAL	WEST	SOUTH
Affordable Housing	1.37	1.56	1.00	1.20	1.04
Employment	.97	.86	.93	1.12	1.23
Shelter	.49	.40	.83	.71	.66
Job Training	.26	.39	.19	.72	.37
Medical Care	.16	.46	.55	.51	.41
Food/Nutrition	.30	.28	.45	.35	.43
Mental Health Care	.58	.33	.24	.23	.27
Literacy/Education	.32	.11	.10	.20	.39
Alcohol Treatment	.25	.21	.24	.11	.14
Child Care	.21	.23	.10	.09	.21
Transportation	.04	.28	.12	.11	.19
Drug Treatment	.11	.21	.07	.03	.03
Clothing	.11	-0-	.05	-0-	.11
Uncertain	-0-	-0-	.05	-0-	-0-

* Score reported = mean ranking on a scale from a maximum value of 3 to a minimum value of 1. About 5% of the responses identified other needs; these were not included in the ranking procedure.

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS COMMUNITY OPINION SURVEY ABOUT SERVICES FOR HOMELESS PEOPLE

Table 19

Most Needed Community Health Care Services for Homeless People

(Rank Order by Respondent Category)*

RANKING

	TOTALS	Advocates/ Service PROVIDERS	Health & Human Service ADMINISTRATORS	Community LEADERS
Outreach Programs	1.06	1.03	1.12	1.04
Special Mental Health Services	1.00	1.02	1.06	.87
Walk-in Health Care Clinics	.88	1.14	.78	.88
Special Alcohol/ Drug Abuse Services	.79	.66	.84	.78
Mobile Health Care Units	.50	.74	.44	.43
Hospital Caseworker Assigned to Homeless	.33	.32	.30	.39
Uncertain	.01	-0-	-0-	.04

* Score reported = mean ranking of each service on a scale from maximum value of 3 to minimum value of 1. About 7% of the responses identified other health care services; these were not included in the ranking procedure.

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS COMMUNITY OPINION SURVEY ABOUT SERVICES FOR HOMELESS PEOPLE

Table 20

Most Needed Community Health Care Services for Homeless People

(Regional Rank Order)*

RANKING

SERVICE	EAST	NORTHEAST	CENTRAL	WEST	SOUTH
Outreach Programs	1.37	.61	1.21	.99	1.06
Special Mental Health Services	1.09	1.26	.88	.89	.96
Walk-in Health Care Clinics	.56	.86	1.10	1.29	.70
Special Alcohol/ Drug Abuse Services	.81	.86	.71	.95	.66
Mobile Health Care Units	.42	.68	.33	.57	.46
Hospital Caseworker Assigned to Homeless	.21	.18	.19	.40	.57
Uncertain	-0-	-0-	.07	-0-	-0-

* Score reported = mean ranking of each service on a scale from maximum value of 3 to minimum value of 1. About 7% of the responses identified other health care services; these were not included in the ranking procedure.

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS COMMUNITY OPINION SURVEY ABOUT SERVICES FOR HOMELESS PEOPLE

Table 21

Who Should Pay for Community Health Services to Homeless People
(Rank-Order of State Total by Respondent Category)*

RANKING

FUNDER	TOTALS	Advocates/ Service PROVIDERS	Health & Hman Service ADMINISTRATORS	Community LEADERS
Federal Government	1.11	1.17	.96	1.39
State Government	1.07	1.00	1.09	1.08
County Government	.82	.79	.90	.69
City Government	.74	.89	.75	.58
Religious/ Private Charities	.39	.60	.36	.28
United Way	.38	.26	.45	.32
Private Health Care Providers	.17	.26	.12	.19
Homeless Themselves	.07	.09	.06	.05
Uncertain	.02	-0-	.04	-0-

* Score reported = mean ranking on a scale from maximum value of 3 to minimum value of 1. About 3% of the responses identified other payers; these were not included in the ranking procedure.

Policy Research on Health Care Needs of Homeless People in Texas

TEXAS COMMUNITY OPINION SURVEY ABOUT SERVICES FOR HOMELESS PEOPLE

Table 22

Who Should Pay for Community Health Services to Homeless People

(Regional Rank-Order)*

RANKING

FUNDER	EAST	NORTHEAST	CENTRAL	WEST	SOUTH
Federal Government	.98	1.00	1.29	.97	1.31
State Government	.97	1.16	.91	1.06	1.17
County Government	.72	.90	.86	.85	.79
City Government	.70	.46	.83	.88	.77
Religious/ Private Charities	.28	.56	.19	.55	.34
United Way	.49	.33	.48	.37	.31
Private Health Care Providers	.04	.32	.14	.23	.13
Homeless Themselves	.07	.09	.07	.09	.03
Uncertain	.05	.02	.05	-0-	-0-

* Score reported = mean ranking on a scale from maximum value of 3 to minimum value of 1. About 3% of the responses identified other payers; these were not included in the ranking procedure.

Appendix E

INDIVIDUALS INTERVIEWED DURING SITE VISITS

INDIVIDUALS INTERVIEWED DURING SITE VISITS

AMARILLO

Diane Barlow
Catholic Family Services

Claudia Blackburn, R. N., M.P.H.
Direrctor of Nursing
Amarillo BiCity-County Health Department

Dave Clark - Executive Director
Panhandle Health Care Coalition
Northwest Texas Hospital

Desi Cohn - Shelter Coordinator
Rape Crisis/Domestic Violence Center

Tanya Graham - Eligibility Screener
Homeless Health Care Project
Panhandle Health Care Coalition
Northwest Texas Hospital

Patty Hamm - Assistant Administrator
Community Development and Housing Administrator
City of Amarillo

Kent Keith - Director
Case Management Services
Texas Panhandle Mental Health Authority

Lyndon Lamb - Case Manager
Homeless Health Care Project
Panhandle Health Care Coalition
Northwest Texas Hospital

Don Prescott - Executive Director
Faith City Mission

Johnny Raymond - Executive Director
Panhandle Community Action Agency

Maj. Cecil O. Sellers - Commanding Officer
Salvation Army

AUSTIN

Don Bauman
Department of Psychology
The University of Texas at Austin

Peggy Boice - Associate Director
United Way of Texas

Ron Kingsberry - Program Director
Salvation Army

Sister Joan Pytlik, D.C., C.F.N.P.
Health Care Planning Consultant
Seton Hospital

Lori C. Renteria
Austin Homeward Bound

CORPUS CHRISTI

Charles Acklen - Executive Director
Coastal Bend Alcoholism Rehabilition Center

Rev. Dick Duncan - Executive Director
Metro Ministries

Annie Harrell - Counseling Coordinator
Metro Ministries

Ruby Hins - Coordinator
Discharge Planning and Patient Education
Memorial County Hospital

Jan Moreno - Executive Director
Women's Shelter of the Corpus Christi Area

Jaye Nelson - Planner
Coastal Bend Council of Governments

Maj. Tom Overton - Commanding Officer
Salvation Army

Lori Rushton - Psychiatric Social Worker
Department of Discharge Planning
Memorial General Hospital

INDIVIDUALS INTERVIEWED DURING SITE VISITS

Fela Leal - Planner
City of Corpus Christi

Annette Sultemeier, R.N., C.P.N. - Director of Nursing
Corpus Christi-Nueces County Health Department

DALLAS

Rev. Ray Bailey - Executive Director
Dallas Life Foundation

Caroline Blackburn -
Dept. of Human Services, Dallas County

Osita Bottorff - Acting Executive Director
Greater Dallas Community of Churches

Doris Bunder - Volunteer
Jewish Coalition for the Homeless

Claudia Burns - DASH Facilitator
Community Council of Greater Dallas

Sandra D. Conway - Substance Abuse Counselor
Homeless Health Care Team - City of Dallas

Pat. A. Cook, M. D. - Director
Health Care for the Homeless Project
Parkland Memorial Hospital

Carol Frank - Director
Social Services
Salvation Army

Rev. John Gardner - Executive Director
Union Gospel Mission

Adela N. Gonzalez, M.P.A. - Director
City of Dallas Health & Human Services

Nann Goplerud - Reporter
WFAA-TV Channel 8

John Guy - Vice President
Agency Relations
United Way of Metropolitan Dallas, Inc.

Buena V. Henry - Senior Counselor
Dallas Southwest Field Office
Texas Rehabilitation Commission

Father Jerry Hill - Director
Austin Street Shelter

Linda Himelstein - Director
Downtown Dallas Family Shelter

Leonard C. Long - Executive Director
West Dallas Community Centers

David Lybarger, R.N. - Family Nurse Practitioner
Homeless Health Care Team - City of Dallas

Carol Madison - Program Specialist
Mental Health Association of Dallas County

Eileen McMenemy, R.N. - Emergency Rm. Liaison Nurse
Homeless Health Care Team
Parkland Memorial Hospital

Lilly Mitchell, M.S.W. - Social Worker
Emergency Room & Ambulatory Clinic
Parkland Memorial Hospital

Virginia Morris - Board Member
Community Outreach Coalition

Richard Nash - Alcohol & Substance Abuse Caseworker
Dallas County MHMR Center

Susan Palmer - Assistant Director
of Human Services, City of Dallas
Dept. of Health and Human Services

Terry Paul - Caseworker
Community Outreach Coalition

Kay Peterson - Psychiatric Nurse
Homeless Health Care Team - City of Dallas

Lori Pistor - Director
The Stewpot, First Presbyterian Church

Sue Reed
Community Resources Division
Dallas Police Department

Fred Pond, R.N., C.F.N.P., M.S.N.
Adult Health Nursing Supervisor
Homeless Health Care Team - City of Dallas

Louella Porviter - Caseworker
Homeless Health Care Team - City of Dallas

INDIVIDUALS INTERVIEWED DURING SITE VISITS

Bert Holmes - Editorial Reporter
Dallas Times-Herald

EDINBURG

Polly Adams - Program Administrator
Tropical Texas Center for
Mental Health-Mental Retardation

Anna Fike - Office Manager
Texas Employment Commission

Dr. Humberto Gonzalez - Clinical Director
Alcohol & Drug Abuse Programs
Tropical Texas Center for MHMR

Maribel Navarro - Executive Director
County of Hidalgo Community Services Agency

EL PASO

Joe Acosta - Research & Planning
Texas Department of Human Services

Jose Aguilar - Executive Director
Project BRAVO

Dolores Briones-Ybarra - Director
Family Planning Clinic
R.E. Thomasson General Hospital

Terry Call - Executive Director
Southwest AIDS Council

Mary Ann Davis - Research & Planning
Texas Department of Human Services

Pete Duarte
Centro Salud Familiar La Fe

JoAnn Escarcega - El Paso Coordinator
Guadalupe Economic Services Corp.

Ruben Garcia - Director
Annunciation House

Mario Martinez - Area Manager
El Paso Office
Texas Rehabilitation Commission

Paula Mitchell - Division Chair
Health Occupations
El Paso Community College

Bill Myers - Public Information Officer
Life Management Center

Dr. Diana Natalicio - President
The University of Texas at El Paso

Hector Nava - Director
El Paso General Assistance

Rosemary V. Neill - Director of Human Services
Rio Grande Council of Governments

Eleanor Poe, R.N. - Director
Baptist Clinic

Jose Quinones - Planner
United Way of El Paso

Daniel Ramirez - Executive Director
St. Anne's Center

Major Neil H. Saunders - Commanding Officer
Salvation Army

Hilliard Smith - Director
Center for Ecumenical Aid to Transients

Rev. Wayne Thorton - Executive Director
Rescue Mission of El Paso

Sr. Mary Walz - Acting Coordinator
Valley Family Health Center

George Ybarra - Research & Planning
Texas Department of Human Services

INDIVIDUALS INTERVIEWED DURING SITE VISITS

FORT WORTH

Souad Abi-Saab, M.S.W. - Social Worker
Homeless Health Care Project
City of Ft. Worth Health Department

Roy Bowen - Manager
Social Services & Admissions
John Peter Smith Hospital
Tarrant County Hospital District

Victoria Clark Royer - Director of Continuity of Care
Tarrant County MHMR Services

Arlene Byrd - Director
Outpatient & Case Management
Tarrant County MHMR Center

Ora Menta Fleming -
Associate Planner & Housing Planner
City of Fort Worth

Capt. Marshall Gestner - Commanding Officer
Salvation Army

Enriqueta Gomez, R.N. - Program Manager
Homeless Health Care Project
City of Ft. Worth Health Department

Ramon Guarjardo - Assistant City Manager
City of Fort Worth

Tony Guinn - Director of Case Management
Tarrant County Council on Alcohol & Drug Abuse

Deborah Kratky - Social Service Supervisor
Texas Department of Human Services

Sharon Marshall - Executive Director
Women's Haven of Tarrant County

Kay McMillen, R. N. - Psychiatric Nurse
Homeless Health Care Project
City of Ft. Worth Health Department

Ann Petruccelli - Associate Manager
Program Development Division
United Way of Tarrant County

Brenda Pool - Planning & Allocation Consultation
United Way of Tarrant County

Francine Pratt, B.S.W. - Director
Northwest InterChurch Agency

Mary Ann Raboin, R. N. - Family Practice Nurse
Homeless Health Care Project
City of Ft. Worth Health Department

Linda Saucedo, M.S.W. - Director
Tarrant County Department of Human Services

Robert E. Scott - Executive Director
Union Gospel Mission

Rev. Andrew Short - Director
Presbyterian Night Shelter

Chris Siegfried - Executive Director
Mental Health Association of Tarrant County

B. Brooks Taylor, M.D., M.P.H. -
Director of Public Health
City of Fort Worth, and Administrator
Homeless Health Care Project

Roger Ward - Regional Operations Director
Fort Worth Office
Texas Rehabilitation Commission

GALVESTON

Janice R. Coggenshall - Mayor
City of Galveston

Ted Hanley - Associate Director
Our Daily-Bread

HARLINGEN

Karen Possum - Executive Director
Family Crisis Center

Frank Vasques - Director of Finance & Planning
Su Clinica Familiar

INDIVIDUALS INTERVIEWED DURING SITE VISITS

HOUSTON

Mamie Arbuckle, R.N. - Case Manager
Homeless Mentally Ill Project
Veterans Administration Hospital

John Paul Barnich - Chairman
Board of Directors
AIDS Foundation of Houston, Inc.

Sylvia Brooks - Vice President
United Way of Harris County

Chuck Burton - Director
Detoxification Unit
The Shoulder Drug Treatment Center

Wilson Canteen, M.S.W. - Case Manager
Homeless Mentally Ill Project
Veterans Administration Hospital

Barbara Castle - Assistant Director
Houston Housing Authoriy

Ellie Collier - Director
Houston Coalition for the Homeless

Evelyn Cox - Director of Education
AIDS Foundation of Houston, Inc.

Scott Cummings - Research Assistant
Homeless Health Care Project
Baylor College of Medicine

Frank Diehl - Executive Director
The Shoulder Drug Treatment Center

Peg Dudar - Executive Director
Westheimer Social Ministry

Rev. Herbert Edminster - Director
Women's and Family Shelter
Star of Hope

Glenda Gardner - Planner
City of Houston

Kent Gasaway - Executive Director
The Open Door Shelter

William Greer - Administrator
Harris County Department
of Social Services

Linda Hunt, C. N. P. Nursing Supervisor
Homeless Health Care Project
Baylor College of Medicine

Jon Johnson - Executive Director
Star of Hope Shelter

Alice Laine, Ph.D.
University of Houston Downtown

Evangeline Landers - Director
Salvation Army Family Residence

Les Lovell - Regional Director
Houston Regional Office
Texas Rehabilitation Commission

Edward E. Mayo, Ph.D. - Clinical Supervisor
Cenikor Foundation, Inc.

Jim Milhauser - Program Director
Houston Regional Office
Texas Rehabilitation Commission

Michael Mizwa - Grants Manager Director
The Shoulder Drug Treatment Center

Virginia Moyer, M.D. - Assistant Chief
Community Medicine Service
Baylor College of Medicine
& Director - Health Care Group/
Homeless Project

Betsy Schwartz, President
Houston Coalition for the Homeless and
Exec. Director - Harris County MHMR

Virginia L. Scott, R.N., M.S.N. - Director
Emergency/Ambulatory Clinics
Ben Taub General Hospital

Charmaiane Smith - Counselor
The Salvation Army Family Shelter

Alberta Smith-Sanders - Substance Abuse Counselor
Homeless Health Care Project
Cenikor Foundation, Inc.

Ron Sparks - Director of Social Services
AIDS Foundation of Houston, Inc.

Darla Whitman - Program Director

INDIVIDUALS INTERVIEWED DURING SITE VISITS

Sylvia Guthrie - Director, WIRES
Houston Area Women's Center

Thomas Hyslop, M.D., M.P.H. - Director
Harris County Health Department

Adult Mental Health Services
MHMR Authority of Harris County

Sandy Young -
Harris County Mental Health-Mental Retardation

LUBBOCK

Rev. Domingo Chapa - Director
Lubbock Life Christian Ministries

Carol Crump - Assistant Regional Administrator
Texas Department of Human Services

Pamela A. Felder - Administrative Assistant
City of Lubbock

Carolyn Lanier - Executive Director
South Plains Food Bank

Richard Lopes - Executive Director
Guadalupe Economic Services, Corp.

Gene Menefee - Executive Director
Lubbock Mental Health-Mental Retardation Center

Pat Morris, A.C.S.W. - Social Services Coordinator
Lubbock General Hospital

Kathy Pope - Mental Health Director
Lubbock Mental Health-Mental Retardation Center

Miguel C. Rincon - Loan Specialist
HUD Field Office

Amy Robertson - Social Worker
Salvation Army

Alice Segovia, L.V.N. - Health Coordinator
Homeless Health Care Project
Guadalupe Economic Services Corp.

The Honorable Robert Shaw - County Judge
County of Lubbock

Sam Silva - Manager
Employment & Social Services
Guadalupe Economic Services Corp.

Harry Stokley, Jr. - Homeless Services Coordinator
HUD Field Office

Maj. John Tharp - Commanding Officer
Salvation Army

Susan Thompson - Program Director for
Adult Protective Services and Community Care
for the Aged and Disabled

Gene Valentini - Deputy Director
Guadalupe Economic Services Corp.

Mary Valentini - Regional Director
Lubbock Regional Office
Texas Rehabilitation Commission

Mary Villanueva, B.S.W. - Social Worker
Lubbock General Hospital

Pat Williams - Executive Director
Presbyterian Center

McALLEN/PHARR

Lupe Aboud - Crime Victim Advocate
Mujeres Unidas/Women United

Guy Bevil - Executive Director
American Red Cross

Estela DeAnda - Executive Director
Mujeres Unidas/Women United

Barbara King - Reporter
The Monitor

Kito Leal - Planner
Nuestra Clinic del Valle
Hidalgo County Health Care Corporation

Pat Moyer - Executive Director

INDIVIDUALS INTERVIEWED DURING SITE VISITS

Hildalgo Count United Way

SAN ANTONIO

Dr. Marvin Abney - Director
Veterans Outreach Center

Richard Alvarado - Vice President
Div. of Strategic Planning & Program Development
United Way of San Antonio & Bexar County

Charles Bower, M.D. - Associate Executive Director
Medical Services/Emergency & Ambulatory Services
Bexar County Hospital District

Msgr. Dermot Brosnan - Executive Director
The Patrician Movement

Dick Brown - Director
Department of Programs for the Homeless
United Way of San Antonio & Bexar County

Ron Burris - Manager, Grants & Contracts
United Way of San Antonio & Bexar County

Joyce Coleman - Executive Director
Bexar County Battered Women's Shelter

Dennis Dugan - Director (SAMM)
San Antonio Metropolitan Ministries Shelter

Irma Escamilla - Director
Social Services
Salvation Army

Julian Flores - Supervisor
Texas Rehabilitation Commission

Martin Garza - Director
Crisis Intervention Center
Bexar County MHMR Center

Anna Guerra - Outreach Caseworker
Homeless Health Care Project
United Way of San Antonio & Bexar County

Sr. Naomi Hayes - Co-Director
Visitation House

Sr. Lea Holzum - Director
St. Philip's Clinic

Bianca McKee, R.N. - Nurse
Homeless Outreach Project
Audie Murphy Veterans Hospital

Steve Metraux - Volunteer
Educational & Social Service
SAMM Shelter

Bill Merritt - Outreach Caseworker
Homeless Health Care Projecet
United Way of San Antonio & Bexar County

Kevin Moriarity - Director
Department of Human Resources
City of San Antonio

Berta Phillips, R.N. - Nursing Supervisor
SAMM Homeless Health Clinic

Shirley Rendon - Outreach Caseworker
United Way of San Antonio & Bexar County

Sr. Mary Sapp - Executive Director
Benedictine Health Resource Center

Steve Shivranah - Social Worker
Homeless Outreach Project
Audie Murphy Veterans Hospital

Mary Stefl, Ph.D.
Department of Health Care Administration
Trinity University

Ruth Steinfeld - Counselor
Crisis Intervention Center
Bexar County MHMR Center

Ruth Stewart, R.N.
School of Nursing
The University of Texas Health Science Center

John Towery - Counselor
Crisis Intervention Center
Bexar County MHMR Center

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TEXAS COMMUNITY OPINION SURVEY ABOUT SERVICES FOR HOMELESS PEOPLE

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Appendix G

BIBLIOGRAPHY

Copies of this bibliography with any or all references annotated may be obtained from the

Benedictine Health Resource Center
285 Oblate Dr.
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(512)377-0457

Ad Hoc Coalition for Health Care for the Homeless. (1987). Grant Application to United States Department of Health and Human Services. Public Health Service, for McKinney Act Health Care for the Homeless Funds . Houston, TX: Harris County Hospital District, P.O. Box 66769, Houston, TX, 77266.

Adult Mental Health Task Force. (1987). "The Dallas Model: A Community- Based System of Treatment for People with Long Term Mental Illness", Mental Health Association of Dallas County, 1-42.

American Public Health Association. (1985). National Leadership Workshop on the Homeless Mentally Ill: Proceedings of the Workshop. American Public Health Association, 1015 15th street, NW, Washington D.C. 20005. Final Report 1-39.

Anderson, Ron. (1988). "COPC Clinics, as Part of Mix, Boost Options for Community", Highlights. Parkland Memorial Hospital, Dallas, Texas. vol. 25 (3): 5-6.

American Psychiatric Association Task Force. (1984). "Recommendations of APA's Task Force on ~~the Ho~~meless ~~Menta~~lly Ill",Hospital and Community Psychiatry. vol 35 (9): 909-910.

Appelbaum, Richard. (1984). "Testimony to a joint session of the House Banking Subcommittee on Housing and Community Development and the House Subcommittee on Manpower and Housing Concerning A Report to the Secretary on the Homeless and Emergency Shelter", (Washington, D.C.: United States Department of Housing and Urban Development.), 166-175.

Arce, Anthony, Marilyn Tadlock, Michael Vergare, Stuart Shapiro. (1983). "A Psychiatric Profile of Street People admitted to an Emergency Shelter", Hospital and Community Psychiatry. vol. 34 (9), 812-817.

Austin Travis County MHMR Center. Grant Application to the RWJF: Program for the Chronically Mentally Ill. Application #35. Part III- 21-46.

Austin-Travis County Mental Health Mental Retardation Center. (1987) Grant Application to the Robert Wood Johnson Foundation Program for the Chronically Mentally Ill. Austin, TX: Austin-Travis County MHMR Center, 1430 Collier, Austin, TX 78704.

Baasher T., A.S.E.D. Elhakim, K. El Fawal, R.Giel et al. (1983). "On Vagrancy and Psychosis", Community Mental Health Journal. vol. 19 (1) Spr., 27-41.

Bachrach, Leona. (1984). "Research on Services for the Homeless Mentally Ill", Hospital and Community Psychiatry. vol. 35 (9): 910-913.

Bachrach, Leona. (1984).
"Interpreting Research on the Homeless Mentally Ill: Some Caveats", Hospital and Community Psychiatry. vol. 35 (9): 914-916.

Bachrach, Leona. (1984).
Report and Analytical Summary of a Meeting of DHHS supporting Researchers Studying the Homeless Mentally Ill. NIMH, Rockville Maryland, April 12-13, 1984. 1-14

Baker, Susan G., David A. Snow. (in press).
The Homeless in Texas: Estimates of Population Size and Demographic Composition. Westport, Connecticut: Greenwood Press.

Ball, Jessica and Barbara Havassy. (1984).
"A Survey of the Problems and Needs of Homeless Consumers of Acute Psychiatric Services," Hospital and Community Psychiatry. vol. 35 (9): 917-921.

Bassuk, Ellen L. (1984).
"The Homelessness Problem", Scientific American. vol. 251 (1): 40-45.

Bassuk, Ellen, Lenore Rubin, and Alison Lauriat. (1986).
"Characteristics of Sheltered Homeless Families", American Journal of Public Health. vol. 76 (9): 1097-1011.

Baumann, Donald J., Charles Grigsby, Cheryl Beauvais & D. Franklin Schultz. (1985).
The Austin Homeless. Final Report to the Hogg Foundation for Mental Health. Austin, TX: University of Texas at Austin. May.

Baumann, Donald J., Randall Osborne, Mary Osborne & Doyle Nelms. (1988).
"The Subjective Underestimation of Problems by the Homeless: A Puzzle Solved by Theory", Unpublished manuscript. University of Texas, Austin, TX.

Baumann, Donald, & Charles Grigsby. (1988).
"Understanding the Homeless: From Research to Action", Unpublished manuscript. University of Texas, Austin, TX.

Baumohl, Jim, D.S.W. (1987).
The Homeless Population with Alcohol Problems. National Institute on Alcohol Abuse. Montreal, Quebec, Canada: School of Social Work, McGill University.

Baxter, Ellen, & Kim Hopper. (1981).
Private Lives/Public Spaces: Homeless Adults on the Streets of New York City Community Service Society, Institute for Social Welfare Research, 105, East 22nd street, New York, NY 10010. 1-129. Supported by a grant from the Ittleson Foundation, Inc.

Bazzoli, Gloria J. (1986).
"Health Care for the Indigent: Overview of Critical Issues", Health Services Research. vol. 21 (3): 354-393.

Bean, Gerald J., Mary Stefl, Steven Howe. (1987).
"Mental Health and Homelessness-Issues and Findings", Social Work , Sep-Oct 87, 411-416.

Beauvais, Cheryl, Donald J. Baumann, Charles Grigsby & D.Franklin Schultz. (1988). "Social Support and the Homeless: Getting By with a Little Help from My Friends", Unpublished manuscript. University of Texas, Austin, Texas.

Bexar County Mental Health Mental Retardation Center. (1986). Grant Application to the Robert Wood Johnson Foundation Project for the Chronically Mentally Ill. San Antonio, TX: Bexar County MHMR.

Blume, Sheila. (1987). "Women and Alcohol", Brown University Digest of Addiction Theory and Application. vol. 6, 58-62.

Breakey, William. (1987). "Treating the Homeless", Alcohol Health and Research World. vol. 11, 42-47+.

Brickner, Phillip W. (1985). "Health Issues in the Care of the Homeless" Health Care of Homeless People ed. Brickner et al. New York: Springer Publishing Co., Inc.

Cardenas, Jose A.; Robledo, Maria del Refugio; Waggoner, Dorothy. (1988). The Undereducation of American Youth. Intercultural Development Research Association.

Cardenas, Jose A.; Robledo, Maria del Refugio; Supik, Josie D. (1986). Texas School Dropout Survey Project: A Summary of Findings. San Antonio: Intercultural Development Research Association. October 31.

Carnrike, C.L.M. and Linda Clayton. (1985). "Wherever I Can...".: Demographic Composition, Lifestyle Factors, Institutionalized History and Perceived Needs of the Homeless in Fort Worth. Report to the Mayor's Committee on the Homeless in Fort Worth. Fort Worth, TX: Office of the Mayor. Nov. 22.

Chailkin, Harris. (1985). Report on the Homeless: The Service Needs of Shelter Care Residents. Baltimore City Health Department, Division of Mental Health, Alcohol and Addictions.

City of Austin. (1985). Task Force on the Homeless: Final Report, July, 1986.

City of Baltimore Health Department. (1986). The Baltimore City Omnibus MH Plan: A Program for Services to the CMI. --application to the RWJF. May.

City of Dallas Department of Health and Human Services. (1987). Grant Application to United States Department of Health and Human Services, Public Health Service, for McKinney Act Health Care for the Homeless Funds. Dallas, TX: City of Dallas, Department of Health and Human Services, 1500 Marilla Street, Dallas, TX, 75201.

City of Dallas, Department of Health and Human Services, Planning, Research, & Evaluation Unit. (1985).
Starting Anew in the City of Dallas,1985: an Exploratory and Descriptive Study of Refugee Groups Using Secondary Sources. pages 1-108.

City of Fort Worth Department of Public Health. (1987)
Grant Application to United States Department of Health and Human Services. Public Health Service, for McKinney Act Health Care for the Homeless Funds. Fort Worth, TX: City of Fort Worth Department of Public Health.

Clark, Wayne. (1985).
"Financial and Developmental Aspects of Housing for the Homeless with Alcohol Related Problems", The Homeless with Alcohol Related Problems. ed. F.D. Wittman and M. Arch. for the Planning and Financial Management Branch, National Institute on Alcohol Abuse and Alcoholism. MD: Rockville.

Coalition for the Homeless. (1984)
Crowded Out: Homelessness and the Elderly Poor in New York City. New York: Coalition for the Homeless, 105 E. 22nd St. New York, New York, 10010.

Cohen, Neal, Jane Putnam, and Ann Sullivan. (1984).
"The Mentally Ill Homeless: Isolation and Adaptation" Hospital and Community Psychiatry. vol. 35 (9): 922-924.

Committee for Economic Development. (1987).
Children in Need: Investment Strategies for the Educationly Disadvantaged. New York: Committee for Economic Development, 1987.

Community Outreach Coalition. (1987)
"Report on the Homeless Mentally Ill Clients Served January 1985 to December 1987", Dallas, TX: Community Outreach Coalition, 5868 Elderwood, Dallas, TX, 75320.

Cooper, Nancy. (1985).
Report - After Shelters: Providing Permanent Housing for Homeless Families and Individuals. Boston: Citizens Housing and Planning Association, Inc., 7 Marshall St., Boston, Mass. 02108.

Council on Research and Development, American Hospital Association. (1986).
"Health Care for the Indigent: Research Agenda for the Future", Health Services Research. vol. 21 (3): 395-401.

Crystal, Stephen. (1982).
New Arrivals: First-Time Shelter Clients. Report Prepared for Human Resources Administration, Family and Adult Services. New York, NY: Human Resources Administration. (November).

Dallas County Mental Health/Mental Retardation Center. (1987)
Grant Application to the Robert Wood Johnson Foundation Program for the Chronically Mentally Ill. Dallas, TX: Dallas Co. MHMRC.

Dallas Health Care for Homeless Coaltion. (1984).
Robert Wood Johnson Health Care for the Homeless Grant Application.
Dallas, TX: City of Dallas, 1500 Marilla Street, City Hall, 7A North,
Dallas, TX, 75201.

Deinstitutionalization Supportive Services Subcommittee of the Governor' Homeless Advisory Board. (1983).
Deinstitutionalization: Report to the Governor's Homeless Advisory Board.
Boston, Mass., February 28.

Denver Department of Health and Hospitals. (1986).
Proposal to RWJF- To Develop a Stable, Comprehensive, Integrated System of Care for the CMI Persons in the City and County of Denver, Colorado.

Dyer, James; Jeff Claassen. (1988).
"The Homeless Seen as a Serious Problem", Austin: The Texas Poll, March 16.

Fagan, Ronald, Armand Mauss, (1987).
"Rehabilitating Skid Row Alcoholics", Brown University Digest of Addiction Therapy and Application. vol. 6 (2), 26-34.

Farr, Rodger K.
"A Mental Health Treatment Program for the Homeless Mentally Ill in the L.A. Skid Row Area", Treating the Homeless: Urban Psychiatry's Challenge.
ed. Billy E. Jones. The Monograph Series of the American Psychiatric Press, 66-92.

Farr, Rodger K. (1985).
"A Programmatic View of the Homeless Mentally Ill in L.A. County", International Journal of Family Psychiatry. vol. 6 (2), 129-148.

Farr, Rodger K., Paul Koegel, Audrey Burnam. (1986).
A Study of Homelessness and Mental Illness in the Skid Row Area of Los Angeles. L.A. County Department of Mental Health, 2415 W. 6th street, L.A. CA 90057. (213) 738-4832. pages 1-294. Executive Summary 1-28.

Filice, Gregory A., et al. (1984).
"Group A Meningococcal Disease in Skid Rows: Epidemiology and Implications for Control", American Journal of Public Health. vol. 74 (3): 253-254.

First, Richard, J., Dee Roth and Bobbie Darden Arewa. (1988).
"Homelessness: Understanding the Dimensions of the Problem for Minorities", Social Work. March-April. 120-124.

Fischer, Pamela J., William Breakey. (1987).
"Profile of the Baltimore Homeless with Alcohol Problems", Alcohol Health and Research World. vol. 11 38-39+.

Fischer, Pamela, Sam Shapiro, William Breakey, James Anthony, Morton Kramer, (1986).
"MH and Social Characteristics of the Homeless: A survey of Mission Users", American Journal of Public Health. vol. 76, 519-524.

Flynn, Kevin. (1985).
"The Toll of Deinstitutionalization", Health Care of Homeless People. ed. Brickner et al., New York: Springer Publishing Co., chp. 14.

Fort Worth Committee on the Homeless. (1987).
Report on the Homeless in Fort Worth. Fort Worth, TX: Office of the Mayor, April.

Franklin, Jack L.,PhD., et. al. (1987).
"An Evaluation of Case Management", American Journal of Public Health. vol. 77 (6)

Friedholm, DeAnn; Team, Linda. (1988).
Current Spending & Future Trends in Health & Human Services for the State of Texas. Texas Foundation of Human Services, Texas IMPACT, People First.

Friedner, D. Wittman; M. Arch, (1987).
"Alcohol, Architecture and Homelessness", Alcohol Health & Research World vol. 11, 74-78.

Garrett, Gerald R.
"Alcohol and the Homeless: an Overview of Research", Sociology Department, University of Mass., Boston, 2-8.

Gittleman, Martin. (1985).
"Systems, Issues and Leadership Roles", National Leadership Workshop on the Homeless Mentally Ill: Proceedings of the Workshop. American Public Health Association, 1015 15th street, NW, Washington D.C. 20005.

Government Research Corporation. (1988).
Options for Meeting Health Care Requirements of Uninsured Individuals: A Report of a Task Force. Washington, D.C.: The Government Research Corporation.

Governor's Advisory Board on the Shelter, Nutrition and Service Program for Homeless People. (1986).
Homelessness: Recommendations for State Action. Maryland: DHR Public Information Office. November.

Guadalupe Economic Services Corporation. (1987).
Grant Application to United States Department of Health and Human Services. Public Health Service, for McKinney Act Health Care for the Homeless Funds . Lubbock, TX: Guadalupe Economic Services Corporation, 1416 First St., Lubbock, TX, 79401.

Hamilton County MH Board. (1986).
Grant Application to the RWJF: Program for the CMI and Modification to the RWJF Grant Application.

Harney, John; Nick Linsalaata; Ann Voke. (1986)
John Hancock Newsletter Background Extra. Boston, Massachusetts; John Hancock Mutual Life Insurance Company.

Holden, Constance. (1985).
"The Neglected Disease in Medical Education", Science. vol. 229 (4715): 741-742.

Holden, Constance. (1986).
"Homelessness: Experts Differ on Root Causes", Science. vol. 232. 569-570.

Hombs, Ellen, Mitch Snyder. (1983).
"The Woman who Died in a Box", Homelessness in America: A Forced March to Nowhere. Washington, D.C.: Community for Creative Non-Violence, 1345 Euclid St. NW 20009.

Hombs, Mary E., Mitch Snyder. (1983).
"Signs and Symptoms: a Look at 29 Cities", Homelessness in America: A Forced March to Nowhere". Washington, D.C.: CCNV, 1345 Euclid St.,N.W. 20009, (202) 332-4332; 121-128.

Hombs, Mary E., Mitch Snyder. (1983).
"Life on the Streets", Homelessness in America: A Forced March to Nowhere. Washington, D.C.: CCNV, 108-120.

Hombs, Mary E., Mitch Snyder. (1983).
"Oral Testimony", Homelessness in America: A Forced March to Nowhere" , Washington, D.C.: CCNV, 129-133.

Hombs, Mary E., Mitch Snyder. (1983).
"Mental Health, Mental Hospitals, and the Homeless", Homelessness in America: A Forced March to Nowhere , Washington, D.C.: CCNV, 43-54.

Hombs, Mary E., Mitch Snyder. (1983).
"A Proposed Policy toward the Elimination of Homlessness in the District of Columbia", Homelessness in America: A Forced March to Nowhere , Washington, D.C.: CCNV, 135-137.

Hombs,Mary E., Mitch Snyder. (1983).
"Policies that Kill", Homelessness in America: A Forced March to Nowhere. Washington, D.C.: CCNV.

Hopper, Kim & Jill Hamberg. (1984).
The Making of America's Homeless: From Skid Row to New Poor 1945 - 1984 . Working Papers in Social Policy. New York, NY: Community Service Society of New York, 105 East 22 street, New York, NY, 10010. December.

Hopper, Kim, Ellen Baxter, Stuart Cox, Laurence Klein. (1982).
"One Year Later - The Poor in New York City, 1982", Community Service Society, 105, East 22nd St., New York, NY 10010.

Hopper, Kim. (1984).
"Some Comments Regarding the Recently Issued Report on the Homeless and Emergency Shelter by the United States Department of Housing and Urban Development", i A Report to the Secretary on the Homeless and Emergency Shelter; Washington, D.C.: United States Department of Housing and Urban Development, 38-52.

Hopper, Kim. (1983).
"A Quiet Violence: The Homeless Poor in New York City, 1982", Homelessness in America: A Forced March to Nowhere. CCNV, 1345 Euclid St., N.W., Washington D.C. 20009.

Hopper, Kim. (1985).
"Housing policy and Issues affecting the Homeless Mentally Ill"National Leadership Workshop on the Homeless Mentally Ill: Proceedings of the Workshop. American Public Health Association, 1015 15th street, NW, Washington D.C. 20005.

Houston Coalition for the Health Care for the Homeless Program. (1984).
Robert Wood Johnson Foundation Grant Application for Health Care for the Homeless. Houston, Tx: Houston Coalition for Health Care for the Homeless.

Hudson, Christopher G. (1988).
"The Development of the Homeless: The Role of Research", Social Thought. Winter, vol. 14 (1), 3-15.

Hudson, Michael; Rosenbaum, Sara; Lanham, Leslie. (1985).
Understanding the Texas Indigent Health Legislation: What It Means for Children and Their Families. Washington, D.C.: Children's Defense Fund, 1985.

Jones, Robert. (1983).
"Street People and Psychiatry: An Introduction", Hospital and Community Psychiatry. vol. 34 (9), 807-811.

Kanter, Arlene. (1985).
"Legal Issues pertaining to the Homeless Mentally Ill",National Leadership Workshop on the Homeless Mentally Ill: Proceedings of the Workshop. American Public Health Association, 1015 15th street, NW, Washington D.C. 20005.

Kasinitz, Philip. (1984).
"Gentrification and Homelessness: The Single Room Occupant and the Inner City Revival", Urban and Social Change Review, vol. 17(1): 9-14.

Kellerman,Sara L., Ronnie S. Halper, Marybeth Hopkins, Gail B. Nayowith. (1985).
"Psychiatry and Homelessness: Problems and Programs", Health Care of the Homeless. ed. Brickner et al.,New York, NY: Springer Publishing Co., ch.13.

Kellogg, F. Russell, Olga Piantieri, Barbara Conanan, Patricia Doherty, William J. Vicic & Philip W. Brickner. (1985).
"Hypertension: A Screening and Treatment Program for the Homeless", ed. Philip W. Brickner et al. Health Care of Homeless People. New York: Springer Publishing Co., Inc. 109-119.

Kelly, John T. (1985).
"Trauma: With the Example of San Francisco's Shelter Programs", ed. Philip W. Brickner et al. Health Care of Homeless People. New York: Springer Publishing Co., Inc. 77-91.

Keyes, Langley C. (1988).
Housing and the Homeless. Cambride, MA: MIT Center for Real Estate Development. March.

Kline, Michael V., John Bacon, Morris Chinkin, William Manov. (1987).
"The Client Tracking System: A Tool for Studying the Homeless", Alcohol Health and Research World. vol. 11, 66-67+.

Koegel, Paul & Audrey Burnam, (1987).
"Traditional and Non-Traditional Homeless Alcoholics", Alcohol Health and Research World. vol. 11, 28-34.

Korenbaum, Sue & Gina Burney. (1986).
"Alcohol-Free Living Environments for Homeless Individuals-Final Report, prepared for the NIAAA by the United States Department of Health and Human Services, under contract no. 86M001296701D; 1-33.

Korenbaum, Sue, Gina Burney. (1987).
"Program Planning for Alcohol-Free Living Center", Alcohol Health & Research World. vol. 11, 68-73.

Kozol, Jonathan. (1988).
"A Reporter at Large: The Homeless and their Children--Part I", The New Yorker. January 25: 65-84.

Kozol, Jonathan (1988)
"A Reporter at Large: The Homeless and their Children--Part II", The New Yorker. February 1: 36-67.

Kroll, Jerome, Kathleen Cary, Dulce Hagedorn, Peter Fire Dog, and Ellen Benavides. (1986).
"A Survey of Homeless Adults in Urban Emergency Shelters", Hospital and Community Psychiatry. vol. 37 (3): 283-286.

Lamb, Richard. (1985).
"Mental Health and Support Services", National Leadership Workshop on the Homeless Mentally Ill: Proceedings of the Workshop.
American Public Health Association, 1015 15th street, NW, Washington D.C. 20005.

League of Women Voters of Minneapolois. (1984).
Home Sweet Home--Until 7 AM: Emergency Housing in Minneapolis. Minneapolis, Minn.: The League of Women Voters. May.

Levine, Irene S., Loretta Haggard. (1987).
"NIMH Initiatives for the Homeless Mentally Ill", Alcohol Health and Research World. vol. 11, 18-19+.

Levy, Litrelle T., Barbara Henley. (1985).
"Psychiatric Care for the Homeless: Human Beings or Cases?", Health Care of Homeless People. ed. Brickner, Philip W., et al. New York: Springer Publishing Co., Chp.15.

Lewis, Rosalie. (1986).
"Undesirable Neighbors", American Journal of Nursing. vol. 86 (5), 535-536.

Life Management Center. (1987).
Grant Application to the Robert Wood Johnson Foundation Project for the Chronically Mentally Ill. El Paso, TX: Life Management Center, P.O. Box 9997 El Paso, TX, 79990.

Lipton, Frank R., Albert Sabatini, Steven Katz. (1983).
"Down and Out in the City: The Homeless Mentally Ill", Hospital and Community Psychiatry. vol. 34 (9), 817-821.

Lubran, Barbara. (1987).
"Alcohol Related Problems among the Homeless- NIAAA 's Response", Alcohol Health and Research World.v ol. 11 (3).

Lucas County MH Board,Toledo, Ohio. (1986).
Lucas County: A Pioneering Approach to Restructuring Community Resources for Severely Mentally Disabled Person: Deliberate Designs and Careful Choices.

MacGregor, Rob R., (1987).
"Alcohol and Immune Defense", Brown University Digest of Addiction Theory and Application. vol. 6, 33-36.

Marcuse, Peter. (1987).
"A Shame of the Cities: Why are they Homeless?", The Nation . April 4: 426-429.

Maricopa Association of Governments (1985).
"Results of Project to Count the Homeless Who Request/Use Social Services in Maricopa County", Phoenix, AZ: Human Services Planning Office.

Martinez, Pablo E., Ph.D. (1988).
Characteristics of the Texas Prison Admissions. Austin, Texas; Texas Board of Pardons and Paroles. March 16, 1988.

Mayor's Task Force on Downtown Alcoholism. (1985).
Final Report of the Mayor's Task Force on Downtown Alcoholism. Portland, OR: City of Portland, Office of the Mayor.

Mayor's Task Force on the Downtown Homeless. (1984).
Final Report of Mayor's Task Force on Downtown Homeless. San Diego, CA: Mayor's Office, City of San Diego.

McAdam, John, Philip W. Brickner, Roslynn Glicksman, Dearborn Edwards, Brian Fallon & Philip Yanowitch. (1985).
"Tuberculosis in the SRO/Homeless Population", ed. Philip W. Brickner et al. Health Care of Homeless People. New York: Springer Publishing Co., Inc. 155-175.

McCarthy, Colman., (1984).
"Just What the Homeless Needed", The Washington Post. Saturday, May 12.

Meagher, Kate. (1986).
"No Place Like Home", New Age Journal. January, 40-80.

Milburn, Norweeta G., Roderick J. Watts, Susan L. Anderson. (1984)
An Analysis of Current Research Methods for Studying the Homeless. Washington, D.C.: Institute for Urban Affairs and Research, Howard University.

Miskura, Susan M., (1988).
"Shelter/Street Night Enumeration Proposal for the 1990 Decennial Census", Memorandum from the United States Department of Commerce, Washington, D.C. Feb 1

Morse, Gary, Nancy M. Shields, Christine P. Hanneke, George J. McCall, et al. (1986)
"St. Louis' Homeless: Mental Health Needs, Services, and Policy Implications", Psychosocial Rehabilitation Journal. vol. 9(4): 41-50.

Michigan Department of Mental Health.
project supported by NIMH Grant #5H84-MH35823-04S1; report prepared by Mowbray, Carol, Andrea Solarz, Sue "Mental Health and Homelessness in Detroit: A Research Study"

Mulkern, Virginia, and Rebecca Spence. (1984).
Alcohol Abuse/Alcoholism Among Homeless Persons: A Review of the Literature. Final Report, National Institute of Alcohol Abuse and Alcoholism, Nov. 9.

National Housing Task Force. (1988).
A Decent Place to Live: The Report of the National Housing Task Force. March,

National Mental Health Association. (1987).
Urgent Relief for Homeless: A Summary of the Stewart B. McKinney Homeless Assistance Act of 1987 (PL 100-77). Alexandria, Virginia; National Mental Health Association.

Newton, Stephen P., Charles Duffy. (1987).
"Old Town Portland and Oldtime Problem", Alcohol Health and Research World. vol. 11, 62-65+.

New York State Department of Social Services, Cesar H. Perales, Commissioner, 1984.
"Homelessness in New York State" a Report to the Governor and the Legislature vol I and II, 1-48; 1-43.

Noble, John, Thomas Scott, Laura Cavicci, & Paul E. Robinson. (1985).
"The Problem of Infections: The Experience of the City of Boston's Shelter for the Homeless", Health Care of Homeless People. ed. Philip W. Brickner et al. New York: Springer Publishing Company, Inc. 93-102.

Nueces County Community Action Agency. (1987).
Grant Application to United States Department of Health and Human Services. Public Health Service for McKinney Act Health Care for the Homeless Funds. Corpus Christi, TX: NCCAA, 3105 Leopard St., Suite One, Corpus Christi, TX, 78405.

Panhandle Health Care Coalition. (1987).
Grant Application to United States Department of Health and Human Services. Public Health Service, for McKinney Act Health Care for the Homeless Funds. Amarillo, TX: Amarillo Hospital District, P.O. Box 2168, Amarillo, TX, 79105.

Phoenix South Community Mental Health Center. (1983).
The Homeless of Phoenix: Who are They and What Should Be Done?. Report prepared for the Consortium for the Homeless. Phoenix, AZ: Phoenix South Community Mental Health Center. June.

Podolsky, Doug. (1986).
"The NIAAA Laboratory of Preclinical Studies", Alcohol Health and Research World. Winter 1985-86: 2-5.

Public Technology, Inc. (1985)
Caring for the Hungry and Homeless: Exemplary Programs. Alexandria, VA: Emergency Food and Shelter National Board Program, United Way Plaza, Alexandria, VA, 22314-2088. June.

Ridgely, Susan M., et al. (1987).
Chronic Mentally Ill Young Adults With Substance Abuse Problems: A Review of Research, Treatment, and Training Issues. Baltimore, Maryland: The University of Maryland at Baltimore. December, 1987.

Rivlin. Leanne G. (1985).
"Making a Difference: Concern for the Homeless", Invited Address for the American Psychiatric Association Conference. Los Angeles, CA. August.

Robert Wood Johnson Foundation. (1988).
Report on the Management of Health Care for the Homeless Projects. Princeton, New Jersey: January 19.

Ropers, Richard & Richard Boyer. (1987)
"Homelessness as a Health Risk", Alcohol Health and Research World. vol. 11, 38-41+.

Ropers, Richard, Marjorie Robertson, and Richard Boyer. (1985).
The Homeless of Los Angeles County: An Empirical Evaluation. Los Angeles: UCLA, Basic Research Project, Document No. 4, January.

Rosenheck, Robert, MD., et al. (1987).
Progress Report on the Veterans Administration Program for Homeless Chronically

Rossi, Peter H., James D. Wright, Gene A. Fisher, Georgianna Willis. (1987).
"The Urban Homeless: Estimating Composition and Size", Science. vol. 235, 1136-1141. March 31, 1987.

Roth, Dee, Jerry Bean. (1985).
"Alcohol and Homelessness: Findings from the Ohio Study", The Homeless with Alcohol-Related Problems. ed. F.D. Wittman and M. Arch. For Planning and Financial Management Branch National Institute on Alcohol Abuse and Alcoholism. MD: Rockville.

Roth, Dee, Jerry Bean, Nancy Lust & Traian Saveanu. (1985).
Homelessness in Ohio: A Study of People in Need. Statewide Report of the Ohio Department of Mental Health, Office of Program Evaluation and Research. February.

Roth, Dee, Gerald Bean. (1986).
"New Perspectives on Homelessness: Findings from a Statewide Epidemiological Study", Hospital and Community Psychiatry. vol. 37 (7): 712-719.

Rutenberg, Gary. (1985).
"Report on Demographic Composition and Health Status of Ft. Worth's Homeless", Fort Worth, TX: Fort Worth Department of Public Health.

Sadd, Susan & Douglas Young. (1987).
"Non-Medical Treatment of Indigent Alcoholics: a Review of Recent Research Findings", Alcohol Health and Research World. vol. 11, 48-49+.

Sadd, Susan. (1985).
"The Revolving Door Revisited: Public Inebriates' Use of Medical and Nonmedical Detoxification Services in New York City", The Homeless with Alcohol Related Problems, ed. F.D. Wittman and M. Arch. for the Planning and Financial Management Branch NIAAA. Rockville MD.

Scheibel, James, Fred Mertz, & Janice Rettmann. (1982).
Final Report: Committee on Street People. St. Paul, MN: City of St. Paul Committee on Street People.

Schussheim, Morton J. (1986).
"The Reagan 1987 Budget and the Homeless", Congressional Research Service Document IP031414. Washington, D.C.: Library of Congress. March 20.

Schwab, Jim. (1986).
"Sheltering the Homeless", Planning. December: 24-27.

Senate Interim Committee on Hunger and Nutrition.
Faces of Hunger in the Shadow of Plenty. Austin, Texas; Senate Interim Committee.

Shandler,Irving W., Thomas Shipley Jr. (1987).
"New Focus for an Old Problem: Philadelphia's Response to Homelessness", Alcohol Health and Research World. vol. 11, 54-57+.

Shapiro, Isaac; Greenstein, Robert. (1988).
Holes in the Safety Nets: Poverty Programs and Policies in the States: A National Overview. Washington, D.C.: Center on Budget and Policy Priorities.

Shapiro, Isaac; Greenstein, Robert, 1988.
Texas--Holes in the Safety Nets: Poverty Programs and Policies in the States. A State Analysis, Washington, D.C.: Center on Budget and Policy Priorities.

Shipley, Thomas E., Joseph O. Moor, Jr., Irving W. Shandler & Robert P. McCarthy. (1985).
"Homeless Alcoholics in Philadelphia: An Update", Photocopied manuscript.

Snow, D.A., et al. (1986).
"The Myth of Pervasive Mental Illness Among the Homeless", Social Problems. vol. 35 (5), 407-423.

Snow, David A.; Leon Anderson. (1987).
"Identity Work Among the Homeless: The Verbal Construction and Avowal of Personnal Indetities", American Journal of Sociology. vol 92 (6) May: 1336-71.

Special Report. (1983).
"Sheltering the Homeless in the Nation's Capital", Hospital and Community Psychiatry. vol. 34 (9), 863 +.

Sperry, Bryan P.; L. Carl Volpe. (1987).
"Problems of Uninsured Remain Significant", Texas Hospitals. 42:10, 12-14.

Stark, Louis. (1987).
"A Century of Alcohol and Homelessness: Demographics and Stereotypes", Alcohol Health and Research World. vol. 11, 8-13.

Stefl, Mary E. (1987).
"The New Homeless: A National Perspective", The Homeless in Contempory Society. ed. Bingham, Richard T.; Roy E. Green; Sammis B. White. Beverly Hills, CA: Sage Publishing Company, Inc. 46-63.

Stern, Mark J. (1984).
"The Emergence of the Homeless as a Public Problem", Social Service Review. vol. 58 (2): 291-301.

Stoil, Michael. (1987).
"Salvation and Sobriety", Alcohol Health and Research World. vol. 11, 14-17.

Stoner, Madeleine R. (1984).
"An Analysis of Public and Private Sector Provisions for Homeless People", The Urban & Social Change Review. vol. 17 (1) Winter 1984: 3-8.

Stoner, Madeleine R. (1983).
"The Plight of Homeless Women", Social Service Review. vol. 57 (4): 565-581.

Su Clinica Familiar. (1987).
Proposal to Provide Primary Health Care Services to the Homeless Submitted to the Bureau of Health Care Delivery and Assistance, Public Health Service, United States Department of Health and Human Services Under McKinney Act . Harlingen, TX: Su Clinica Familiar Family Health Service Program. October 5.

Surber, Robert W., Eleanor Dwyer, Katherine Ryan, Stephen Goldfinger, John Kelly, 1988.
"Medical and Psychiatric Needs of the Homeless- A Preliminary Response", Social Work. Mar-Apr. 1988, 116-119.

Task Force on Emergency Shelter. (1983).
Homelessness in Chicago. Chicago, IL: Department of Human Services. October.

Task Force on Indigent Health Care. (1984).
Task Force on Indigent Health Care: Final Report to the Governor. Austin, TX: Governor's Office. December.

TDCA Task Force of Affordable Housing. (1987).
Safe and Affordable Housing for Texans: A Public/Private Challenge. May,

1987.

Teshima, Dick Y. (1987).
Alcohol Abuse and Alcoholism Among Homeless. Reports Available from the National Institute on Alcohol Abuse and Alcoholism. August, 1987.

Texas Health and Human Services Coordinating Council. (1985).
Final Report on the Homeless in Texas. Austin, TX: Texas Health and Human Services Coordinating Council. October, 1985.

United States Department of Health and Human Services Task Force. (1984).
The Homeless: Background, Analysis, and Options. Briefing Paper submitted to U.S. House of Representatives Subcommittee on Intergovernmental Relations and Human Resources, Committee of Government Operations, Washington, D.C. 20515.

United States Department of Health and Human Services. (1987).
Innovative State Activities Relating to Alcohol and Drug Treatment Services for the Homeless POP. Prepared by NASADAD (Natl. Assoc. of State Alcohol and Drug Abuse Disorders, contract no.177901., 1-28

United States Department of Housing and Urban Development. (1984).
A Report to the Secretary on the Homeless and Emergency Shelters. Washington, D.C.: United States Department of Housing and Urban Development.

United States General Accounting Office. (1985).
Homelessness: A Complex Problem and the Federal Response. Washington, D.C.: United States General Accounting Office.

United States House of Representatives, 100th Congress. (1987).
Public Law 100-77: Stewart B. McKinney Homeless Assistance Act. Washington, D.C.: 100th Congress.

United Way of America. (1984).
Hunger and Homelessness: Long Term Problems. Report prepared by United Way of America, Government Relations Committee, Issues Subcommittee, 701 N. Fairfax St., Alexandria, VA 22314.

United Way of San Antonio. (1987).
Grant Application to National Institute on Alcoholism and Alcohol Abuse. San Antonio, TX: United Way of San Antonio.

United Way of San Antonio. (1987).
Grant Application to United States Department of Health and Human Services. Public Health Service, for McKinney Act Health Care for the Homeless Funds. San Antonio, TX: United Way of San Antonio.

University of Hawaii, at Manoa. (1986).
Program for the CMI, City and County of Honolulu, Request for Project Support and Conditions of Grant. By Burns School of Medicine, Research Administration.

Vanhorenbeck, Susan (1987).
"Homeless Housing: HUD's Emergency Shelter and Transitional Shelter Program", Congressional Research Service Document IB87098. Washington, D.C.: Library of Congress. March 30.

Westermeyer, Joseph. (1987).
"Public Health and Chronic Mental Illness", American Journal of Public Health vol. 77 (6), June, 1987.

Whitman, David. (1988).
"Hope for the Homeless", U.S. News and World Report. Feb. 29. 25-35.

Whittemore, Hank. (1988).
"We Can't Pay the Rent", Parade Magazine. January 10, 1988: 4-6.

Wiegard, R. Bruce. (1985).
"Counting the Homeless", American Demographics. December 7: 34-37.

Williams, Gerald D., Frederick Stinson, Douglas Parker, Thomas Harford, John Noble. (1987).
"Demographic Trends, Alcohol Abuse, and Alcoholism 1985-1995", Alcohol Health and Research World. vol. 11, 80-83+.

Willis, Peggy. (1981).
Evaluation of Emergency Shelter Services. Report Prepared by City of Seattle Office of Policy and Evaluation. Seattle, WA: Office of Policy and Evaluation. August.

Wiseman, Jacqueline. (1987).
Studying the Problem of Alcoholism in Today's Homeless. Uni. of California, for presentation at NIAAA Conference on the Homeless population with Alcohol Problems, Rockville, MD. 1-21.

Wittman, Friedner D. and M. Arch. (1985).
"Alcohol and Homelessness: An Architectural Response" In The Homeless with Alcohol Related Problems. ed F.D. Wittman and M. Arch for the Planning and Financial Management Branch National Institute on Alcohol Abuse and Alcoholism. MD: Rockville.

Wittman, Friedner D., and M. Arch. (1985).
"Research Recommendations", The Homeless with Alcohol Related Problems. ed. F.D. Wittman and M. Arch for thePlanning and Financial Management Branch, National Institute on Alcohol Abuse and Alcoholism. MD: Rockville.

Wright, Al. (1985).
"Los Angeles County's Response to the Homeless", The Homeless with Alcohol Related Problems, ed. F.D. Wittman and M. Arch for the Planning and Financial Management Branch, National Institute on Alcohol Abuse and Alcoholism. MD: Rockville.

Wright, James. (1985).
"The Johnson-Pew Health Care for the Homeless Program", The Homeless with Alcohol-Related Problems, ed. F.D. Wittman and M. Arch for the Planning and Financial Management Branch National Institute on Alcohol Abuse and Alcoholism. MD: Rockville.

Wright, James D., Janet Knight, Eleanor Weber-Burdin, Julie Lam. (1987). "Ailments and Alcohol- Health Status among the Drinking Homeless", Alcohol Health & Research World. vol. 11, 22-27.

Wright, James D.; Weber, Eleanor. (1987). Homelessness and Health. Washington, D.C.: McGraw-Hill's Healthcare Information Center, 1987.

Wynne, Anne S. (1986). Final Report - Task Force on The Homeless. Austin, TX: City of Austin. August 1.